MENTAL HYGIENE

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# MENTAL HEALTH IN OUR NEW KIND OF WORLD *

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IT is a plain fact that we of the human race who happen to be alive at this moment are in a new kind of world—a world of which none of our ancestors had any experience—where the conditions of survival are different from those of any other time, where the human race is now up against a situation that might be compared to one of the great ice ages that destroyed many forms of life in the earth. Those forms of life in many cases flourished for hundreds of thousands, or millions of years—and then, because they were not able to make a new adjustment to changed circumstances, they disappeared. Many of them lived and flourished for far longer periods than man has lived on earth, but still they disappeared because they could not change their ways enough to adjust to changing circumstances.

Man is in very real danger from exactly that same situation now. He has developed to the point where there is real danger from man himself to the whole human race.

The tensions that we all feel, the anxieties that beset us all, are in some degree valid anxieties. We are up against new situations, in dealing with which we can learn very little from our ancestors—which puts us to the painful necessity of doing our own thinking. And we're not used to it—we find it very uncomfortable indeed and we'll go to extreme lengths to avoid it whenever we can. We'd much prefer to return to our stereotypes—to behave in ways that make us feel that we are good

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little boys and girls and doing as our parents told us to do. And then everything is supposed to be all right. And it isn't. The ways our parents behaved are no longer valid for the survival of the human race at this stage of its development.

Under these types of stresses and strains all the weaknesses of every culture tend to show up. The cracks appear. The difficulties that have not yet been dealt with effectively begin to get attention, because our cultures—our methods of doing things—were not designed to cope with this present situation. They were designed for quite other purposes, and we are again under the painful necessity of recognizing that some of our ways of doing things may well be obsolete. We are going to find out which are obsolete, and which are still valid, and which need to be changed, only by this painful process of looking at them without our prejudices blinding us.

And this is our difficulty for we all have prejudices. They are inherent in our culture, no matter what our culture is, or where we come from—because we have cultural ways of looking at things, attitudes that are typical of our culture, and that make us feel that the way other people from other cultures look at things is not sound, is not right, may even be immoral—just as our ways of looking at things may well be regarded in the same light by those other people.

The time has come, however, when we should begin to look at ourselves. I would suppose that we have experimented enough with telling other people how they should behave—other people in other parts of the world. We've been doing that for a long time and it hasn't been very effective. And it isn't ever going to be very effective. We now need to do something about ourselves.

Perhaps some of you know a statement I would like to quote from the constitution of the World Health Organization, which has been signed by 84 member nations—almost all the people in the world are represented. In the first place, it's a definition of health: "Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." A little later in that same constitution is another statement that is highly significant, representing an attitude of the governments of the peoples of the world about the development of children. It says, "The healthy development of children is of basic importance." Healthy, of course, meaning

physically, mentally, and socially. And it goes on—"The ability to live harmoniously in a changing total environment is essential to that development." This is a vastly important statement. We of the older generations have not been able to live harmoniously, even in a generation whose environment was not changing too rapidly. Yet the nations of the world are saying that the children of the world, now living, must grow up to be able to live harmoniously in a *changing total environment*—meaning that the world is now a different kind of place from what it has ever been before.

All our old behavior patterns are now suspect. Which is not to say that they are wrong or mistaken at all—they may be perfectly valid still. Simply because they are old behavior patterns is not to say that they are valid or that they are not valid. They need to be re-evaluated—all of them. In order to do that, we—the peoples of the world—have got to have a reasonable security inside ourselves, a reasonable standard of mental health, so that we may learn to react adequately and in mature terms toward this changing total environment—so that we may be able to work out for ourselves appropriate new behavior patterns, so that we may be able to change whatever is appropriate to change for this new kind of world. This has never been asked of our ancestors before. It has not been asked of us in our youth. But this is the situation facing the younger people coming along in the world now.

It is to be hoped that within the next few years many people in many places will begin to recognize that their way of living, no matter where it is, must be regarded as experimental—just as experimental as anything set up in a laboratory, where a negative experiment is just as valuable as a positive one. Many of the aspects of every culture of which we know anything should be regarded as negative experiments, because they are *not* working effectively. That is true of *our* culture—no matter who we may be or where we may live.

Mental health will, if it is real mental health, enable us to face up to these new types of realities. Representatives of large groups of people, no matter how they are defined, by race or color or religion or ideology, or nationality, can react only as the people composing such groups want them to react. National delegates can only reflect the attitudes of their peoples. It is disturbing that at meetings of United

Nations Specialized Agencies very frequently national delegates have to make statements, under instructions from their governments, that they *know* to be inappropriate, immature, not civilized to the degree that is necessary for nations of the world now. And many times such delegates will apologetically make such statements—and to those of their friends whose regard they value, they will frequently explain first that they are very sorry that they are going to have to make such-and-such a statement. The world will not be saved in the councils of the nations. If the human race is going to get on with its great evolutionary experiment, it will be as the result of improved mental health amongst the peoples of the world—in their homes and schools, in the cities and towns and villages, in the urban and rural areas. They are the important people—not the diplomats, who follow a long way behind the people of their country.

The mental health movement is one of the great pressures in the direction of sanity and eventually peace on earth. But mental health cannot be given to people by psychiatrists, sociologists, psychologists, or any other kind of technical person. This is a job for the people of the world in their own homes, in their schools, in their churches, everywhere they come together, but particularly in their own homes in relation to the development of their own children. And only to the degree that mental health is a *people's movement,* so that people are learning how to feel and live in a different way, appropriate to a new world, can the mental health movement be effective. That is a responsibility that lies heavily on the shoulders of every person everywhere who is capable of recognizing it.

# NURSING IN PSYCHIATRIC HOSPITALS

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SIGNIFICANT developments have occurred in psychiatric nursing within recent years. Ten years ago, even five years ago, prepared psychiatric nurses were very few in number and were working in virtual isolation from each other. In most cases, their preparation for the care of the mentally ill was meager. It may simply have been a work experience, without any instruction and with only minimal supervision. It may have consisted, either as part of the basic training in nursing or through post-graduate courses, of a few months of exposure to the rigors of life in the wards of a mental hospital, combined with a course of lectures in simplified descriptive psychiatry. Mental hospital employment held little appeal for nurses in general, and the profession as a whole knew little about it.

More recently, there has been an upsurge of interest among nurses, as there has among other professional groups and the general public, in what is happening in psychiatry. Nurses are entering the field in increasing numbers. Basic educational programs are placing as much emphasis on preparation in psychiatric nursing as has traditionally been placed on preparation in pediatric nursing, medical nursing, and other clinical areas. Many universities now offer programs in psychiatric nursing to graduate nurses who wish to extend their preparation to fit themselves for positions as supervisors or nursing service administrators in psychiatric hospitals, or as teachers of basic or advanced students in psychiatric nursing.

The two national nursing organizations, the American Nurses' Association and the National League for Nursing, have appointed several committees to work on various phases of the problem of supplying nursing care, adequate in quantity and quality, for the mentally ill. The organization of the Council on Psychiatric and Mental Health Nursing of the National League for Nursing, which had its beginnings early in 1953 and now has related groups in most of the forty-eight

State Leagues for Nursing, is an important step toward eliminating the separateness and isolation of psychiatric nurses.

How extensive are the changes which have taken place in psychiatric nursing? To what are the new developments attributed? What is their significance? How effective have they been in meeting the needs of the 800,000 mentally ill in the United States? How can the trend toward improvement be developed and strengthened? These are some of the questions which are being asked of and by nurses today.

Although comprehensive statistics on psychiatric nursing are not available, it is evident that the numbers of psychiatric nurses are increasing rapidly. Even the state mental hospitals, which are the most deprived of all types of hospital facilities as far as professional nursing personnel are concerned, have benefited from the increase. The following figures represent the changes which have taken place within a five-year period in five states with widely different resources for state hospital care:

REGISTERED PROFESSIONAL NURSES EMPLOYED IN STATE MENTAL HOSPITALS [1]

| | *1949* | *1954* |
|---|---|---|
| California | 175 | 528 |
| Kansas | 12 | 54 |
| Minnesota | 88 | 171 |
| Ohio | 198 | 268 |
| Oklahoma | 10 | 46 |

Each of these states has instituted, during the past five years, a vastly improved program of treatment in its mental hospitals. It is evident that nurses enter the psychiatric field in increasing numbers as treatment programs develop. Progress in nursing cannot, in any field, antedate progress in medicine. But in individual hospitals, as in the psychiatric field as a whole, nurses come forward to work at the side of the physician when their services are required to promote and supplement a planned program of medical treatment.

Many more psychiatric nurses will eventually be needed, however, than are now available. This is demonstrated in the report of the survey which was done in 1954 as part of the Southern Regional Education Board Mental Health

[1] Figures obtained by personal correspondence.

Project. In the sixteen southern states which were surveyed, it was estimated that more than 10,000 psychiatric nurses are needed. It must be recognized that this estimate of the number of nurses needed is a theoretical one. There definitely are not positions established for 10,000 nurses in the state hospitals of the South, and it is doubtful whether money could be found to support more than a very small fraction of that number.

Until the late 1930's, the care offered to the mentally ill was, in almost all psychiatric facilities, limited to providing for patients' most obvious physical needs. Except for some phases of the task of organizing the nursing care to be given, most of this work could be, and was, left to untrained attendants. As the shock therapies came into use, and, as happened in a few hospitals, some of the patients were given the benefit of group or even individual psychotherapy, there developed a demand for concomitant psychiatric nursing care, and nurses began to move in to fill the gap. Of recent years, the demand on the part of some public hospitals has begun to exceed the supply, and for private hospitals and the rapidly increasing numbers of psychiatric units in general hospitals sufficient numbers of prepared psychiatric nurses to meet employment quotas are difficult to find.

The schools of nursing, of which there are more than 1,100 in the United States, have attempted to keep pace with developments in psychiatry. As facilities for training have become available, more and more schools have arranged for a basic learning experience in psychiatric nursing for their students, until at the present time there are very few which do not provide it. Unfortunately, the arrangements made by a substantial number of schools have been premature. Students who have been sent to poorly developed clinical settings and who have been guided by instructors and supervisors themselves inadequately educated in the specialty, fail to develop a taste for further experience or preparation in psychiatric nursing.

It is generally recognized that the nurse who accepts supervisory and teaching responsibility in any field requires specialized training both in the clinical specialty and in the techniques of teaching and supervision. The need for this specialized training is especially great for nurses in the field of

psychiatry. The subject matter and treatment measures of psychiatry are in an early stage of development, and the choice of treatment measures is still motivated by divergent aims. Heavy and conflicting demands continue, therefore, to be made on those who work in the field.

*Psychiatric Hospital Administration and the Nurse.*—The basic professional program of nursing education, whether controlled by a general hospital or by a university, prepares nurses to accept beginning positions in any of five types of hospital services: medical, surgical, pediatric, obstetric, or psychiatric nursing. A beginning (or general duty) position in nursing is considered to be one in which the nurse works under the immediate supervision of a head nurse. The head nurse, in turn, has charge of a single nursing unit, which is staffed by a few general duty nurses and a larger number of practical nurses or attendants.

In psychiatric facilities, with the exception of the psychiatric units in some general hospitals, there are very few general duty positions available to nurses. When a hospital begins to develop its treatment program there is a tendency to place the few nurses who are available in positions of immediate and heavy responsibility. The young graduate nurse who accepts employment in a psychiatric hospital is, in most instances, expected to assume responsibility for managing a ward which may house fifty or more patients, and for guiding and supervising a number of non-professional workers. In this fact lies one of the reasons why many nurses who enter the psychiatric field do not stay in it, or, if they stay, make only a minimal contribution to it.

When a young nurse assumes responsibility in a psychiatric hospital beyond that for which she is trained, she is unable to achieve satisfaction for herself or to give satisfaction to her employers. If she continues in her position in spite of this, it is as a disgruntled, dissatisfied worker, or else as one who has internalized the unhappy features of the situation to the extent that she is no longer in conflict over them but remains incapable of doing anything to change them. All too often, in addition to living with her own incompetence, the nurse is faced with the need to adjust to an incredibly unfamiliar hospital environment. She finds patients stripped not only of all the material possessions which link them with ordinary human

life, but also of the right to freedom of decision and action, even in the smallest things. The atmosphere in which she spends hour after hour with patients may be characterized by attitudes of watchful waiting for any act on the part of patients which is contrary to the prevailing mores, with the sure reward of even stricter curtailment of the patient's freedom to follow the slightest misdemeanor.

Discriminating young women in nursing, who, as students, are assigned to psychiatric hospitals for a portion of their training, recognize some of these factors and offer them as reasons for not entering the field of psychiatry after graduation. A survey reported in 1952 by the Group for the Advancement of Psychiatry "indicated that nurses leave mental hospitals for the following reasons:

1. Lack of educational and intellectual stimulation
2. Insufficient opportunity for professional growth
3. Poor living conditions in many of the hospitals.

There were also expressions of need for recognition and status and opportunity for active participation on the 'therapeutic team'."[1]

As long as current conditions persist in psychiatric hospitals, nurses as a group will tend to believe that psychiatry has not yet developed to a stage in which the professional nurse of today can make a useful contribution. There is a great need for coöperative planning and action between psychiatrists, especially those who administer psychiatric hospitals or teach students in nursing, and the nursing profession. Little will be accomplished as long as one group settles back and blames the other for the existing state of affairs.

Given a staff of professional personnel with adequate clinical preparation, the requirements for effective and comfortable hospital nursing practice are few. They are: (1) a program of medical treatment in which the nurse can function on a collaborative basis with physicians and others in the remedial care of patients; and (2) a structure of hospital and nursing administration which assures favorable personnel practices, including competent supervision of nursing workers on all levels.

[1] See *The Psychiatric Nurse in the Mental Hospital*, Report No. 22, Group for the Advancement of Psychiatry.

The tendency of the psychiatric hospital administrator to insist on the assignment of nurses on a widely scattered basis throughout the hospital is an understandable one. The administrator, expecting that humaneness and order will come about in the care of patients with the advent of the nurses, wishes to assure these benefits for as many parts of the hospital as possible. This type of assignment means, however, that each nurse works with little or no support or supervision from other nurses. Unless she possesses an unusual degree of professional and personal maturity, she will find herself faced with overwhelming problems and responsibilities.

Those nurses who are assigned to units in which a treatment program has not yet been instituted will find little or no opportunity to make use of whatever psychiatric nursing skills they possess, their time being fully occupied with the purely custodial requirements of the patients. The stultifying effects of this will soon take their toll. Those assigned for prolonged periods to such units as the operating room and the surgical ward will likely experience a similar lack of stimulation and satisfaction. It may be assumed that they entered the field of psychiatry because of their interest in human behavior and how it can be influenced, and will not find the medical and surgical services sufficiently challenging to their capabilities as psychiatric nurses.

It would seem to be essential that nurses and psychiatric hospital administrators work together toward a more rational system of assignment of nurses in psychiatric hospitals. When a hospital is in the early stages of modernizing its program, the nurses should be concentrated in those units in which psychiatric treatment worthy of the name is being instituted. Assignment to medical and surgical units should be a matter of choice among the nurses themselves. In any single unit, an inexperienced nurse should work at the side of a nurse who has had enough experience and special preparation to give her the supervision she needs. In addition, there should be organized throughout the hospital as a whole, a system of nursing administration which will give structure and stability to the nursing service provided for patients.

It has been indicated that psychiatric nurses look for "educational and intellectual stimulation," and "professional growth" in employment situations. A primary source of

these satisfactions might be expected to lie in the relationship which develops between the nurse and the nurse supervisor or nurse administrator. Where supervisory nursing responsibilities are assigned to aides or technicians, the nurse with a truly professional outlook is deprived of this source. It is unlikely that a technician will be able to provide educational and intellectual stimulation even for other technicians. The supervisor should be a person of broad background and high professional attainments, who is capable of inspiring his supervisees, as well as giving them competent guidance.

Nurses in increasing numbers are being educated in advanced programs in psychiatric nursing, that is, in university programs organized to prepare graduate nurses as supervisors, instructors, administrators, or consultants in psychiatric nursing. About twenty-five universities are currently offering advanced programs of study for some or other of these positions.

Through the administration of the National Mental Health Act, official recognition has been given to the professional nurse as an essential worker in psychiatry. Since the Act went into effect in 1947, appropriations have been made to universities to support the education of psychiatrists, psychiatric social workers, clinical psychologists, and nurses. Most of the programs of nursing education mentioned above receive financial support from this source. At the end of the 1953 fiscal year, total expenditures for the development of advanced psychiatric nursing had reached $1,515,000. From 1947 through 1953, 884 traineeship awards had been made.[1]

*An Appraisal of Psychiatric Nursing Education Needed.*— Adequate clinical preparation has been referred to as a primary requisite for good hospital nursing practice. It is obvious that no pre-service program of clinical education can prepare the nurse to cope with some of the problems she will meet in some psychiatric situations. It can be expected that in-service education will need to be provided for all nursing workers throughout their working life in psychiatric hospital service. At the same time, however, an appraisal of psychiatric nursing education in the light of service requirements might result in much needed adjustments in psychiatric nurs-

[1] See "Psychiatric Nursing Education Program Developments," by Esther A. Garrison. *Mental Hospitals*, December, 1953.

ing education as preparation for psychiatric nursing service.

The subject matter of many courses in psychiatric nursing, especially on the basic level, is drawn almost exclusively from descriptive psychiatry. A nurse who has an understanding of the dynamics of behavior, derived from courses in human development as well as from those more strictly related to abnormal conditions, might be expected to develop more helpful relationships with mentally ill patients. However, it will inevitably result that she will be more sensitive to the traumatic features of the psychiatric setting as a whole, especially to attitudes unsympathetic toward patients. Herein lies one of the needs for a reevaluation of both service and education.

Another is related to the lack of agreement among nurses, and between nurses and psychiatrists, about the nature of the relationship which should be developed between nurse and patient. Some of the advanced educational programs, particularly, attempt to help nurses develop psychotherapeutic skills. In contrast to this, regulations are in effect in some hospitals which forbid nurses to discuss with patients either their own or their patients' private affairs. A basic nursing student in a select private hospital, when asked recently by the writer why she thought this rule was made, pondered earnestly, and with parrot-like faithfulness answered, "If the patient talks about his difficulties to the nurse, it will drain off emotional energy that should be reserved for his interviews with the psychiatrist." When personal elements are barred from conversation, there is not much left for people to talk about, and there is nothing on which a relationship can be based.

There is a basic contradiction between training programs and treatment programs in psychiatry which must give rise to difficulty not only for nurses, but for other workers in the field as well. In every teaching program, individual psychotherapy is upheld as the treatment par excellence in psychiatry. In actual practice, very little individual psychotherapy is in evidence. In a hospital in which a nurse accepts employment there may be one or two qualified psychiatrists on a staff serving several thousand patients. If, as might be conjectured, rehabilitation in family and community life is the true aim of most psychiatric hospital care, would it not be useful

to institute programs of treatment toward this end, and teach all types of workers how to contribute to them?

In the more "progressive" educational programs in psychiatric nursing, primary emphasis is inevitably placed on the nursing care of the patient as an individual. This continues to hold true, in spite of the fact that the care and treatment of almost all mentally ill patients is on a mass basis. Granted that the nurse must first learn to deal with her patients as individuals, should her education not be carried beyond this if she is to be adequately prepared to give the kind of care that is needed for psychiatric patients? Even in a private mental hospital of the kind that offers every advantage to patients, it is doubtful whether their hospitalization will be of much benefit to them if each patient is treated as an isolated individual. Life in a hospital ward can, if it is a well ordered part of the treatment regimen, provide a medium through which patients can learn through practice the essentials of healthy human relationships. The nurse is in an ideal position to bring this about, if she is equipped through her educational experience with techniques which enable her to work effectively with her patients as a group. Education in the skills of group dynamics with specific application to psychiatric situations is essential as part of the nurse's learning experience.

One of the most difficult aspects of preparation for nursing in psychiatric hospitals, but at the same time one of the most important, is training that will enable the nurse to work helpfully and in harmony with non-professional workers in psychiatric nursing: aides, attendants, or technicians, as they are variously called. The working relationship of the professional nurse with the well-trained practical nurse is less of a problem, since the latter expects to benefit from professional nursing supervision. It is important that the basic education of nurses be redesigned to prepare them to work in leadership positions in relation to all non-professional nursing personnel. This is necessary in clinical services other than psychiatry in present-day hospital care, much of which is given by nursing workers with little or no formal training. Skill and confidence in leadership should be developed through planned educational experiences, rather than being left for the nurse to pick up as best she can after graduation.

*Psychiatric Aides.*—The psychiatric aide is an indispensable worker in the mental hospital community. As appropriations for public mental hospitals increase, aides are being employed in ever-increasing numbers. With the introduction of treatment programs, something more than merely custodial care of patients is being required of them. It is evident at the present time that aides should be taught simple nursing procedures and how to assist the physician in carrying out somatic forms of treatment. Some nurses and psychiatrists are of the opinion that aides as well as nurses should learn how to develop relationships with patients which will further their progress toward self-realization and self-direction. Aides themselves are beginning to demand opportunities to learn various of these skills as a means both of improving their status and helping them do a worthwhile job.

Many hospitals have instituted on-the-job training programs for aides. In most cases the training is mainly in technical procedures with lectures in simplified psychiatric theory added, and instruction designed to instill ethical attitudes toward patients and other hospital personnel. In exceptional instances, discussion sessions are held through which the aides can learn to understand their patients as individuals and how to exert a therapeutic influence on their behavior.

In view of the overwhelming need, it would seem to be desirable to prepare a group of workers, in less time and at less cost than through general and specialized professional nursing education, to administer some of the interpersonal type of nursing care required by psychiatric patients. It is doubtful whether skilled psychiatric aides can be prepared on an on-the-job basis. An employed worker is much less likely than a full-time student to be motivated toward the abstract type of learning required on all levels in psychiatric nursing. Even if motivation exists, it is doubtful whether education for responsibility and understanding can be obtained on a part-time basis, without opportunity for relatively leisurely reading, discussion and reflection.

The on-the-job psychiatric aide training programs now in existence usually provide for periodic classes of the lecture and demonstration variety, with parallel work experience. The classes are held once or twice a week and in many cases bear little relation to the practice which the aides are carrying

out on the wards, usually under the supervision of other aides. In contrast, the better pre-service education programs for both practical and professional nurses are designed to insure that the care given to patients by students is carefully planned in relation to concomitant instruction and is carried out with the guidance of ward instructors who have had specialized education both in the clinical nursing field and in teaching method.

The national nursing organizations have given considerable attention to the current need for more and better trained personnel to meet the nursing needs of the mentally ill. A special committee of the Coördinating Council of the American Nurses' Association and the National League for Nursing, which is composed of the Boards of Directors of the two organizations, has held two meetings within the past two years to discuss this topic. These meetings were attended by psychiatrists, aides, and nurses, representing hospitals and schools of nursing, and by representatives of such organizations as the American Psychiatric Association, the Council of State Governments, the Group for the Advancement of Psychiatry, the American Hospital Association, the National Federation of Licensed Practical Nurses, the Veterans Administration, the U. S. Department of Health, Education, and Welfare, and the American Federation of State, County and Municipal Employees, in addition to the American Nurses' Association and the National League for Nursing. Many problems relating to psychiatric nursing service, education, and recruitment have been discussed by the committee.

With regard to the education of psychiatric aides, agreement was reached on the desirability of instituting training programs of the pre-service type. Although it was recognized that such programs will not meet the training needs of the thousands of aides now employed, the committee was of the opinion that measures should be taken to insure a supply of better trained workers for the future. In the meantime, on-the-job training of aides should be continued and improved, and continuing in-service education programs should be instituted for all employed psychiatric nursing personnel.

Committees of the National League for Nursing are beginning to work toward the establishment of standards for the various programs which are needed. This is a long-term

project, and should be combined with pilot projects through which different types of programs can be conducted on an experimental basis. During 1953 and 1954, a committee of the American Nurses' Association, comprised of representative psychiatrists, psychiatric nurses and psychiatric aides prepared a statement of the functions of psychiatric aides. This statement will be used as a basis for determining the content of programs of training.

One of the most pressing problems associated with the training of psychiatric aides is that of securing an adequate number of well-prepared instructors. Qualified teachers are scarce in numbers in all areas of nursing education and perhaps especially so in psychiatric nursing. Training in relationships is difficult, and requires a high degree of specialized skill in the teacher. The nursing organizations are working on this and other phases of recruitment into psychiatric nursing education and service.

Promising developments are occurring in psychiatric nursing in terms both of the quantity and quality of personnel in the field. Much remains to be done, however, before anything even approaching adequate nursing care of psychiatric patients can be assured. The task of providing adequate nursing care has been accepted by the nursing profession as being primarily their responsibility. With assistance and support from the public and from their colleagues in other professions, it is hoped that they may be able to make significant progress toward their goal within the next few years.

# MENTAL DISEASE AMONG THE NATIVE AND FOREIGN-BORN WHITE POPULATIONS OF NEW YORK STATE, 1939–1941

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MENTAL diseases do not occur sporadically nor in a strictly random manner. There are patterns in the distribution of mental diseases. For example, their prevalence occurs in a definite sequence in relation to age. The prevalence varies with respect to the urban-rural distribution of population, the rate of first admissions to hospitals for mental disease being higher for urban populations. Among other important variables, is the distribution with respect to nativity. Indigenous populations have lower rates of mental disease than migrant groups. This has been demonstrated with respect to internal migration, but it is also true of migration on a wider scale from country to country, and from continent to continent. A population that is native to a given environment has lower rates of mental disease than the population in the same environment which is of foreign birth.

There is a large literature dealing with differential rates of mental disease between native and foreign-born populations.[1] Practically all such studies have shown that the foreign-born have higher rates of mental disease (as measured by first admissions to hospitals for mental disease) than the native population. This has given rise to great controversy. One set of investigators concluded that immigrants, especially those of the most recent origin, were biologically inferior to the native population. The other investigators deny that differences in rates of mental disease imply racial inferiority, and they stress the more difficult social and economic environments in which immigrants live. In this study, we shall review the evidence with respect to differential rates

[1] See *Social and Biological Aspects of Mental Disease*, by Benjamin Malzberg. Utica: State Hospitals Press, 1940. Chapter VI.

TABLE 1. NATIVE WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, CLASSIFIED ACCORDING TO PRINCIPAL GROUPS OF MENTAL DISEASE

| | *Number of First Admissions* | | | *Per Cent* | | | *Average Annual Rate per 100,000 Population* | | |
|---|---|---|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| General paresis | 938 | 385 | 1,323 | 6.5 | 2.9 | 4.8 | 6.3 | 2.5 | 4.4 |
| Alcoholic | 1,537 | 269 | 1,806 | 10.7 | 2.0 | 6.6 | 10.4 | 1.8 | 6.0 |
| With cerebral arteriosclerosis | 2,053 | 1,808 | 3,861 | 14.3 | 13.8 | 14.0 | 13.9 | 11.9 | 12.9 |
| Senile | 951 | 1,357 | 2,308 | 6.6 | 10.3 | 8.4 | 6.4 | 8.9 | 7.7 |
| Involutional | 474 | 1,029 | 1,503 | 3.3 | 7.8 | 5.4 | 3.2 | 6.8 | 5.0 |
| Manic-depressive | 790 | 1,665 | 2,455 | 5.4 | 12.7 | 8.9 | 5.3 | 11.0 | 8.2 |
| Dementia praecox | 3,862 | 3,615 | 7,477 | 26.8 | 27.5 | 27.2 | 26.1 | 23.8 | 24.9 |
| Other | 3,794 | 3,003 | 6,797 | 26.3 | 22.9 | 24.7 | 25.6 | 19.8 | 22.7 |
| Total | 14,399 | 13,131 | 27,530 | 100.0 | 100.0 | 100.0 | 97.3 | 86.4 | 91.8 |

of mental disease among the native white and foreign white populations in New York State. The data consist of average annual rates of first admissions to all hospitals for mental disease in New York State during the three successive fiscal years which ended June 30, 1941.

During this period, there were 42,563 white first admissions, of whom 27,530, or 64.7 per cent, were native, and 15,033, or 35.3 per cent, were foreign-born. (See Tables 1 and 2.)

TABLE 2. FOREIGN WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, CLASSIFIED ACCORDING TO PRINCIPAL GROUPS OF MENTAL DISEASE

| | *Number of First Admissions* | | | *Per Cent* | | | *Average Annual Rate per 100,000 Population* | | |
|---|---|---|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| General paresis | 761 | 156 | 917 | 9.8 | 2.1 | 6.1 | 17.3 | 3.7 | 10.7 |
| Alcoholic | 715 | 166 | 881 | 9.2 | 2.3 | 5.9 | 16.3 | 4.0 | 10.3 |
| With cerebral arteriosclerosis | 2,153 | 1,715 | 3,868 | 27.8 | 23.6 | 25.7 | 49.0 | 41.0 | 45.0 |
| Senile | 925 | 1,316 | 2,241 | 11.9 | 18.1 | 14.9 | 21.0 | 31.4 | 26.1 |
| Involutional | 394 | 1,010 | 1,404 | 5.1 | 13.9 | 9.3 | 9.0 | 24.1 | 16.4 |
| Manic-depressive | 298 | 632 | 930 | 3.8 | 8.7 | 6.2 | 6.8 | 15.1 | 10.8 |
| Dementia praecox | 1,264 | 1,372 | 2,636 | 16.3 | 18.9 | 17.5 | 28.7 | 32.8 | 30.7 |
| Other | 1,246 | 910 | 2,156 | 16.1 | 12.5 | 14.3 | 28.3 | 21.7 | 25.1 |
| Total | 7,756 | 7,277 | 15,033 | 100.0 | 100.0 | 100.0 | 176.3 | 173.8 | 175.1 |

TABLE 3. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, PER 100,000 POPULATION, CLASSIFIED ACCORDING TO NATIVITY AND SPECIFIED GROUPS OF MENTAL DISEASES

| | *Native (a)* | | | *Foreign-born (b)* | | | *Ratio of (b) to (a) × 100* | | |
|---|---|---|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| General paresis | 6.3 ± 0.2 | 2.5 ± 0.2 | 4.4 ± 0.1 | 17.3 ± 0.7 | 3.7 ± 0.3 | 10.7 ± 0.4 | 274.6 | 148.0 | 243.2 |
| Alcoholic | 10.4 ± 0.3 | 1.8 ± 0.1 | 6.0 ± 0.2 | 16.3 ± 0.7 | 4.0 ± 0.4 | 10.3 ± 0.4 | 156.7 | 222.2 | 171.7 |
| With cerebral arteriosclerosis | 13.9 ± 0.4 | 11.9 ± 0.3 | 12.9 ± 0.2 | 49.0 ± 1.2 | 41.0 ± 1.2 | 45.0 ± 0.8 | 352.5 | 344.5 | 348.8 |
| Senile | 6.4 ± 0.2 | 8.9 ± 0.3 | 7.7 ± 0.2 | 21.0 ± 0.8 | 31.4 ± 1.0 | 26.1 ± 0.6 | 328.1 | 352.8 | 339.0 |
| Involutional | 3.2 ± 0.2 | 6.8 ± 0.2 | 5.0 ± 0.2 | 9.0 ± 0.5 | 24.1 ± 0.9 | 16.4 ± 0.5 | 281.3 | 354.4 | 328.0 |
| Manic-depressive | 5.3 ± 0.2 | 11.0 ± 0.3 | 8.2 ± 0.2 | 6.8 ± 0.4 | 15.1 ± 0.7 | 10.8 ± 0.4 | 128.3 | 137.3 | 131.7 |
| Dementia praecox | 26.1 ± 0.5 | 23.8 ± 0.4 | 24.9 ± 0.3 | 28.7 ± 0.9 | 32.8 ± 1.0 | 30.7 ± 0.8 | 110.0 | 137.8 | 123.3 |
| All first admissions | 97.3 ± 0.9 | 86.4 ± 0.9 | 91.8 ± 0.7 | 176.3 ± 2.3 | 173.8 ± 2.4 | 175.1 ± 1.7 | 181.2 | 201.2 | 190.7 |

TABLE 4. AVERAGE AGE OF NATIVE WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, CLASSIFIED ACCORDING TO MENTAL DISEASES

| | *Average Age (Years)* | | | *Standard Deviation (Years)* | | |
|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total |
| General paresis .... | 45.6 ± 0.3 | 42.9 ± 0.4 | 44.8 ± 0.2 | 11.4 ± 0.2 | 12.2 ± 0.3 | 11.7 ± 0.2 |
| Alcoholic ..... | 45.2 ± 0.2 | 43.6 ± 0.4 | 45.0 ± 0.2 | 10.4 ± 0.1 | 10.9 ± 0.3 | 10.5 ± 0.1 |
| With cerebral arteriosclerosis .... | 68.5 ± 0.1 | 68.4 ± 0.1 | 68.4 ± 0.1 | 8.8 ± 0.1 | 9.1 ± 0.1 | 8.9 ± 0.1 |
| Senile ..... | 77.0 ± 0.2 | 76.9 ± 0.1 | 76.9 ± 0.1 | 7.4 ± 0.1 | 7.7 ± 0.1 | 7.6 ± 0.1 |
| Involutional ..... | 54.3 ± 0.2 | 51.4 ± 0.1 | 52.4 ± 0.1 | 7.4 ± 0.2 | 7.0 ± 0.1 | 7.2 ± 0.1 |
| Manic-depressive .... | 38.7 ± 0.3 | 36.9 ± 0.2 | 37.4 ± 0.2 | 12.8 ± 0.2 | 12.8 ± 0.1 | 12.7 ± 0.1 |
| Dementia praecox.... | 29.4 ± 0.1 | 31.4 ± 0.1 | 30.4 ± 0.1 | 9.4 ± 0.1 | 10.7 ± 0.1 | 10.1 ± 0.1 |
| All first admissions.. | 44.3 ± 0.1 | 45.7 ± 0.1 | 45.0 ± 0.1 | 19.0 ± 0.1 | 19.7 ± 0.1 | 19.3 ± 0.1 |

The latter thus included approximately a third of the total first admissions, though they included only 22 per cent of the total white population of New York State in 1940.[1] The average annual rate of first admissions per 100,000 corresponding population was 91.8 for native whites and 175.1 for foreign whites. The latter was therefore in excess by 90.7 per cent. Among males the rate for the foreign-born was in excess by 81.2 per cent. The excess for the foreign females was even greater, rising to 101.2 per cent.

Reference to Table 3 will show that the rates for the foreign-born whites were higher for each of the leading groups of mental diseases. The least excess, 23.3 per cent, occurred in connection with dementia praecox. The greatest differences occurred among the psychoses associated with advanced age, and with the involutional psychoses. In each of these groups, the rate for the foreign whites was in excess by over 200 per cent. With respect to general paresis, the rate for the foreign whites was in excess by 143.2 per cent. The excess in connection with the alcoholic psychoses was much smaller, amounting to only 71.7 per cent.

In this form the data clearly imply that the foreign-born had higher rates of mental disease than the native born. This is an improper conclusion to draw at this point, however, because it implies that the two populations were alike in all respects with relation to those factors which influence the

[1] See "Characteristics of the Population" in *Population*, second series; Sixteenth Census of the United States, 1940. Washington, D. C.: U. S. Government Printing Office, 1942, p. 10.

TABLE 5. AVERAGE AGE OF FOREIGN WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, CLASSIFIED ACCORDING TO MENTAL DISEASES

| *Mental Diseases* | *Average Age (Years)* | | | *Standard Deviation (Years)* | | |
|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total |
| General paresis ..... | 50.2 ± 0.2 | 49.6 ± 0.7 | 50.1 ± 0.2 | 10.0 ± 0.2 | 12.6 ± 0.4 | 10.4 ± 0.2 |
| Alcoholic ..... | 50.8 ± 0.3 | 51.8 ± 0.6 | 51.0 ± 0.2 | 9.9 ± 0.2 | 10.9 ± 0.4 | 10.1 ± 0.2 |
| With cerebral arteriosclerosis ... | 67.5 ± 0.1 | 68.0 ± 0.1 | 67.7 ± 0.1 | 9.0 ± 0.1 | 8.8 ± 0.1 | 8.9 ± 0.1 |
| Senile ..... | 77.3 ± 0.2 | 77.0 ± 0.2 | 77.1 ± 0.1 | 7.2 ± 0.1 | 8.5 ± 0.1 | 7.8 ± 0.1 |
| Involutional ..... | 53.7 ± 0.2 | 51.3 ± 0.1 | 52.1 ± 0.1 | 6.4 ± 0.2 | 6.2 ± 0.1 | 6.3 ± 0.1 |
| Manic-depressive .... | 46.2 ± 0.4 | 41.9 ± 0.3 | 43.3 ± 0.3 | 11.5 ± 0.3 | 10.9 ± 0.2 | 11.3 ± 0.2 |
| Dementia praecox.... | 39.2 ± 0.2 | 40.2 ± 0.2 | 39.8 ± 0.1 | 10.3 ± 0.1 | 10.3 ± 0.1 | 10.3 ± 0.1 |
| All first admissions.. | 56.4 ± 0.1 | 56.5 ± 0.1 | 56.4 ± 0.1 | 15.9 ± 0.1 | 16.8 ± 0.1 | 16.4 ± 0.1 |

occurrence of mental disease, and differ only in their racial and associated biological characteristics. Now, rates of first admissions for mental disease are higher for males than for females, and they are higher for older groups than for younger populations. In both of these respects, the foreign white population is at a disadvantage, and attention must therefore be directed to these factors.

In the first place, there were more females than males in the native white population in 1940, the ratio being 100 males to 102.7 females. Among foreign whites, on the contrary, there were 100 males to only 95.3 females.[1]

The differences were even more marked with respect to age.[2] The median age for the foreign whites in 1940 was 48.2 years, compared with only 37.2 years for the native whites. Rates of mental disease are lower among those under 20 years of age. This age group included 36.4 per cent of the native white population in New York State in 1940, but only 2.7 per cent of the foreign white population. The excess was still evident at ages 20 to 34, though not so marked. This age interval included 28.8 per cent of the native and 14.1 per cent of the foreign white population. In age groups 35 to 59, however, the native white population included only 26.7 per cent of the total, compared with 61.8 per cent of the foreign whites. Rates of mental disease are highest among those of advanced age. Those aged 60 or over included 20.4 per cent of the

[1] *Op. cit.*, p. 10.
[2] *Ibid.*, p. 13.

TABLE 6. AVERAGE ANNUAL STANDARDIZED RATES OF WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, PER 100,000 POPULATION, CLASSIFIED ACCORDING TO NATIVITY AND SPECIFIED GROUPS OF MENTAL DISEASES

| | *Native (a)* | | | *Foreign-born (b)* | | | *Ratio of (b) to (a) × 100* | | |
|---|---|---|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total | Males | Fe-males | Total |
| General paresis* | 10.2 ± 0.3 | 3.9 ± 0.2 | 6.9 ± 0.2 | 12.6 ± 0.6 | 3.3 ± 0.3 | 7.8 ± 0.4 | 123.5 | 84.6 | 113.0 |
| Alcoholic** | 18.7 ± 0.4 | 3.1 ± 0.2 | 10.7 ± 0.2 | 13.1 ± 0.6 | 3.7 ± 0.4 | 8.3 ± 0.4 | 70.1 | 119.3 | 77.6 |
| With cerebral arteriosclerosis† | 65.8 ± 0.9 | 48.2 ± 0.7 | 59.3 ± 0.5 | 81.3 ± 1.6 | 65.9 ± 1.4 | 76.8 ± 1.1 | 123.6 | 136.7 | 129.5 |
| Senile† | 29.4 ± 0.5 | 32.0 ± 0.5 | 34.0 ± 0.4 | 36.4 ± 1.1 | 48.8 ± 1.3 | 47.3 ± 0.9 | 123.8 | 152.5 | 139.1 |
| Involutional‡ | 9.3 ± 0.3 | 20.6 ± 0.4 | 14.6 ± 0.3 | 9.6 ± 0.5 | 29.0 ± 1.0 | 18.7 ± 0.5 | 103.2 | 140.8 | 128.1 |
| Manic-depressive* | 7.7 ± 0.3 | 14.9 ± 0.4 | 11.3 ± 0.2 | 7.7 ± 0.5 | 17.3 ± 0.8 | 12.6 ± 0.4 | 100.0 | 116.1 | 111.5 |
| Dementia praecox* | 31.2 ± 0.5 | 29.5 ± 0.5 | 30.4 ± 0.4 | 44.4 ± 1.2 | 39.5 ± 1.1 | 42.1 ± 0.8 | 142.3 | 133.9 | 138.4 |
| All first admissions* | 142.4 ± 1.2 | 120.3 ± 1.0 | 132.1 ± 0.8 | 154.4 ± 2.2 | 142.8 ± 2.2 | 150.5 ± 1.5 | 108.4 | 118.7 | 113.9 |

* Population of New York State aged 15 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.
** Population of New York State aged 20 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.
† Population of New York State aged 45 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.
‡ Population of New York State aged 35 years or over on April 1, 1940 (in intervals of 5 years) taken as standard.

foreign whites, compared with only 8.0 per cent of the native whites. Clearly, therefore, the crude rates were spurious to a certain degree, because of differences with respect to the relative distribution according to sex and age in the two populations. It must therefore be determined what is the effect of reducing the comparisons to a comparable base with respect to these two factors.

Table 6 provides standardized rates of first admissions. The population used as the standard was that of New York State, aged 15 years or over, on April 1, 1940, the population being taken in intervals of five years. In the case of the males, the standardized rates were 142.4 per 100,000 population for the native whites, and 154.4 for the foreign whites. The latter was in excess by only 8.4 per cent, compared with an excess of 81.2 per cent on the basis of crude rates. In the case of the females, the corresponding standardized rates for native and foreign whites were 120.3 and 142.8, respectively. This represents an excess of 18.7 per cent for the foreign white females, in contrast with an excess of 101.2 per cent on the basis of crude rates. Finally, holding both sex and age proportions constant, we obtain standardized rates of 132.1 for the native whites, and 150.5 for the foreign whites. The excess of the latter amounted to 13.9 per cent, compared with an original excess of 90.7 per cent. Thus, by merely eliminating the effects of varying sex and age proportions, the difference in the rates of first admissions was reduced by almost 80 per cent.

When we consider individual groups of mental disorders, similar reductions are in evidence, with one important exception. The crude rate for dementia praecox was higher for the foreign-born than for the native population by 23.3 per cent. Correction for the differences in the proportions with respect to age and sex raised the excess to 38.4 per cent. This resulted from an upward revision among males. On the basis of crude rates, the foreign male rate exceeded that of native males by only 10 per cent, but the standardized male rate was in excess by 42.3 per cent. Standardization resulted in a slight decrease in the excess of the rate for foreign-born females.

In all other cases, there were large and significant changes as a result of standardization. On the basis of crude rates, the rates for the foreign-born were in excess by over 200 per cent with respect to psychoses with cerebral arteriosclerosis,

TABLE 7. AVERAGE ANNUAL RATES OF WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941, PER 100,000 POPULATION, STANDARDIZED ACCORDING TO SEX, AGE, AND URBAN-RURAL DISTRIBUTION, CLASSIFIED ACCORDING TO NATIVITY AND SPECIFIED GROUPS OF MENTAL DISEASES

| | *Native (a)* | | | *Foreign-born (b)* | | | *Ratio of (b) to (a) × 100* | | |
|---|---|---|---|---|---|---|---|---|---|
| *Mental Diseases* | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| General paresis* | 10.7 ± 0.3 | 3.9 ± 0.2 | 7.2 ± 0.2 | 11.6 ± 0.6 | 3.1 ± 0.3 | 7.3 ± 0.3 | 108.4 | 79.4 | 101.4 |
| Alcoholic** | 19.9 ± 0.4 | 3.2 ± 0.2 | 11.4 ± 0.2 | 12.2 ± 0.6 | 2.9 ± 0.3 | 7.1 ± 0.3 | 61.3 | 90.6 | 62.3 |
| With cerebral arteriosclerosis† | 71.1 ± 0.8 | 49.4 ± 0.7 | 63.3 ± 0.5 | 73.6 ± 1.5 | 58.1 ± 1.4 | 69.7 ± 1.1 | 103.5 | 117.6 | 110.1 |
| Senile† | 32.1 ± 0.5 | 32.7 ± 0.5 | 36.6 ± 0.4 | 31.3 ± 1.0 | 42.4 ± 1.2 | 42.4 ± 0.8 | 97.5 | 129.7 | 115.8 |
| Involution‡ | 10.6 ± 0.3 | 21.3 ± 0.4 | 15.6 ± 0.3 | 9.0 ± 0.5 | 27.4 ± 0.9 | 17.7 ± 0.5 | 84.9 | 128.6 | 113.4 |
| Manic-depressive* | 7.9 ± 0.3 | 15.2 ± 0.4 | 11.7 ± 0.2 | 7.4 ± 0.4 | 16.4 ± 0.7 | 12.1 ± 0.4 | 93.7 | 107.9 | 103.4 |
| Dementia praecox* | 32.6 ± 0.5 | 29.8 ± 0.5 | 31.4 ± 0.4 | 42.0 ± 1.1 | 37.0 ± 1.1 | 39.9 ± 0.8 | 128.8 | 124.2 | 127.1 |
| All first admissions* | 149.6 ± 1.2 | 121.7 ± 1.0 | 137.7 ± 0.8 | 143.4 ± 2.1 | 132.8 ± 2.1 | 140.5 ± 1.5 | 95.9 | 109.1 | 102.0 |

* Population of New York State aged 15 years or over on April 1, 1940 (in intervals of 5 years), with urban-rural proportions of that date, taken as standard.

** Population of New York State aged 20 years or over on April 1, 1940 (in intervals of 5 years), with urban-rural proportions of that date, taken as standard.

† Population of New York State aged 45 years or over on April 1, 1940 (in intervals of 5 years), with urban-rural proportions of that date, taken as standard.

‡ Population of New York State aged 35 years or over on April 1, 1940 (in intervals of 5 years), with urban-rural proportions of that date, taken as standard.

senile psychoses, and involutional psychoses. By correcting for differences with respect to age and sex, however, the rates for the foreign-born were reduced to such a degree that they exceeded those for the native whites by only 20 to 40 per cent. With respect to general paresis, the rate for the foreign-born was in excess by only 13 per cent. Due to a very low rate among the foreign-born males, the standardized rate for the alcoholic psychoses was only 77.6 per cent of that for the native whites. In the case of the manic-depressive psychoses, the standardized rate for the foreign-born was in excess by only 11.5 per cent.

It is possible, in this way, to introduce one factor after another, in which the two populations differ significantly. One of the most important is the different economic status of the two populations. Unfortunately, the necessary statistical data are not readily available. There is one respect, however, in which the foreign-born and the native populations differ significantly, and that is the degree of urbanization. It is known that the rate of first admissions is higher for urban than for rural populations.[1] Of the foreign-born, 91.8 per cent were living in urban areas on April 1, 1940, compared with 79.6 per cent for the native white population.[2] This is a significant difference. It is, therefore, necessary to adjust further the rates of first admissions for the native and foreign populations so as to correct for this bias. In the final adjustments, therefore, the two populations were compared on the basis of similar distributions with respect to sex, age, and urban-rural proportions. The results are summarized in Table 7.

We began with a crude rate of 175.1 per 100,000 population among the foreign white population, compared with 91.8 for the native white population. When corrected with respect to differential sex and age proportions, the corresponding rates became 150.5 and 132.1, respectively. Introducing the additional correction for the urban-rural rates, the rates became 140.5 for the foreign white population, and 137.7 for the native population. Beginning with an excess of 90.7 per cent, when no account was taken of sex and age proportions, the disparity was reduced to 13.9 per cent, when such corrections were made.

[1] Benjamin Malzberg, *op. cit.* Chapter 3.

[2] See *Population, op. cit.*, p. 14.

TABLE 8. NATIVE WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| Under 10 | 99 | 34 | 133 | 0.7 | 0.3 | 0.4 | 4.0 | 1.4 | 2.7 |
| 10–14 | 147 | 85 | 232 | 1.0 | 0.6 | 0.8 | 9.9 | 5.9 | 7.9 |
| 15–19 | 848 | 705 | 1,553 | 5.9 | 5.4 | 5.6 | 54.7 | 46.0 | 50.4 |
| 20–24 | 1,426 | 1,207 | 2,633 | 9.9 | 9.2 | 9.6 | 94.1 | 75.8 | 84.7 |
| 25–29 | 1,416 | 1,458 | 2,874 | 9.8 | 11.1 | 10.4 | 99.4 | 95.9 | 97.6 |
| 30–34 | 1,462 | 1,339 | 2,801 | 10.2 | 10.2 | 10.2 | 114.8 | 101.6 | 108.0 |
| 35–39 | 1,419 | 1,193 | 2,612 | 9.9 | 9.1 | 9.5 | 132.5 | 109.2 | 120.7 |
| 40–44 | 1,286 | 1,055 | 2,341 | 8.9 | 8.0 | 8.5 | 135.0 | 108.7 | 121.7 |
| 45–49 | 1,127 | 1,004 | 2,131 | 7.8 | 7.6 | 7.7 | 139.8 | 122.5 | 131.1 |
| 50–54 | 1,053 | 893 | 1,946 | 7.3 | 6.8 | 7.1 | 162.8 | 133.6 | 147.9 |
| 55–59 | 774 | 696 | 1,470 | 5.4 | 5.3 | 5.3 | 159.9 | 134.1 | 146.5 |
| 60–64 | 774 | 702 | 1,476 | 5.4 | 5.3 | 5.4 | 196.7 | 159.1 | 176.8 |
| 65–69 | 769 | 759 | 1,528 | 5.3 | 5.8 | 5.6 | 254.4 | 211.6 | 231.1 |
| 70–74 | 650 | 682 | 1,332 | 4.5 | 5.2 | 4.8 | 322.8 | 273.3 | 295.4 |
| 75 or over | 1,149 | 1,319 | 2,468 | 8.0 | 10.0 | 9.0 | 603.3 | 491.8 | 538.1 |
| Total | 14,399 | 13,131 | 27,530 | 100.0 | 100.0 | 100.0 | 97.3 | 86.4 | 91.8 |

TABLE 9. FOREIGN WHITE FIRST ADMISSIONS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 10–14 | 2 | 2 | 4 | * | * | * | 7.2 | 7.3 | 7.3 |
| 15–19 | 57 | 41 | 98 | 0.7 | 0.6 | 0.7 | 79.3 | 57.0 | 68.1 |
| 20–24 | 112 | 82 | 194 | 1.4 | 1.1 | 1.3 | 147.7 | 91.2 | 117.0 |
| 25–29 | 207 | 234 | 441 | 2.7 | 3.2 | 2.9 | 128.3 | 110.1 | 118.0 |
| 30–34 | 354 | 407 | 761 | 4.6 | 5.6 | 5.1 | 111.9 | 115.7 | 113.9 |
| 35–39 | 526 | 625 | 1,151 | 6.8 | 8.6 | 7.7 | 107.2 | 129.2 | 118.2 |
| 40–44 | 718 | 631 | 1,349 | 9.3 | 8.7 | 9.0 | 124.7 | 117.0 | 121.0 |
| 45–49 | 797 | 742 | 1,539 | 10.3 | 10.2 | 10.2 | 127.3 | 134.4 | 130.6 |
| 50–54 | 920 | 781 | 1,701 | 11.9 | 10.7 | 11.3 | 146.8 | 152.2 | 149.2 |
| 55–59 | 825 | 630 | 1,455 | 10.6 | 8.7 | 9.7 | 169.1 | 153.1 | 161.8 |
| 60–64 | 765 | 634 | 1,399 | 9.9 | 8.7 | 9.3 | 210.8 | 190.1 | 200.9 |
| 65–69 | 722 | 637 | 1,359 | 9.3 | 8.8 | 9.0 | 288.7 | 255.6 | 272.2 |
| 70–74 | 669 | 629 | 1,298 | 8.6 | 8.6 | 8.6 | 408.1 | 365.4 | 386.2 |
| 75 or over | 1,082 | 1,202 | 2,284 | 14.0 | 16.5 | 15.2 | 747.9 | 736.6 | 742.1 |
| Total | 7,756 | 7,277 | 15,033 | 100.0 | 100.0 | 100.0 | 176.3 | 173.8 | 175.1 |

* Less than 0.05.

TABLE 10. NATIVE WHITE FIRST ADMISSIONS WITH GENERAL PARESIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| Under 10 | ... | 1 | 1 | ... | 0.3 | 0.1 | ... | * | * |
| 10–14 | 6 | 1 | 7 | 0.6 | 0.3 | 0.5 | 0.4 | 0.1 | 0.2 |
| 15–19 | 6 | 9 | 15 | 0.6 | 2.3 | 1.1 | 0.4 | 0.6 | 0.4 |
| 20–24 | 7 | 9 | 16 | 0.7 | 2.3 | 1.2 | 0.4 | 0.6 | 0.5 |
| 25–29 | 26 | 28 | 54 | 2.8 | 7.3 | 4.1 | 1.8 | 1.8 | 1.8 |
| 30–34 | 115 | 52 | 167 | 12.3 | 13.5 | 12.6 | 9.0 | 3.9 | 6.4 |
| 35–39 | 158 | 69 | 227 | 16.8 | 17.9 | 17.2 | 14.8 | 6.3 | 10.4 |
| 40–44 | 159 | 63 | 222 | 17.0 | 16.4 | 16.8 | 16.7 | 6.6 | 11.5 |
| 45–49 | 148 | 50 | 198 | 15.8 | 13.0 | 15.0 | 18.4 | 6.1 | 12.2 |
| 50–54 | 131 | 40 | 171 | 14.0 | 10.4 | 12.9 | 20.3 | 6.0 | 13.0 |
| 55–59 | 82 | 28 | 110 | 8.7 | 7.3 | 8.3 | 16.9 | 5.4 | 11.0 |
| 60–64 | 50 | 17 | 67 | 5.3 | 4.4 | 5.1 | 12.7 | 3.9 | 8.0 |
| 65–69 | 28 | 12 | 40 | 3.0 | 3.1 | 3.0 | 9.3 | 3.3 | 6.1 |
| 70–74 | 10 | 4 | 14 | 1.1 | 1.0 | 1.1 | 5.0 | 1.6 | 3.1 |
| 75 or over | 12 | 2 | 14 | 1.3 | 0.5 | 1.1 | 6.3 | 0.7 | 3.1 |
| Total | 938 | 385 | 1,323 | 100.0 | 100.0 | 100.0 | 6.3 | 2.5 | 4.4 |

* Less than 0.05.

TABLE 11. FOREIGN WHITE FIRST ADMISSIONS WITH GENERAL PARESIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 15–19 | ... | 4 | 4 | ... | 2.6 | 0.4 | ... | 5.6 | 2.8 |
| 20–24 | ... | ... | ... | ... | ... | ... | ... | ... | ... |
| 25–29 | 8 | 2 | 10 | 1.1 | 1.3 | 1.1 | 5.0 | 0.9 | 2.7 |
| 30–34 | 22 | 10 | 32 | 2.9 | 6.4 | 3.4 | 7.0 | 2.8 | 4.8 |
| 35–39 | 74 | 20 | 94 | 9.7 | 12.8 | 10.3 | 15.1 | 4.1 | 9.7 |
| 40–44 | 154 | 22 | 176 | 20.2 | 14.1 | 19.2 | 26.8 | 4.1 | 15.8 |
| 45–49 | 141 | 23 | 164 | 18.5 | 14.7 | 17.9 | 22.5 | 4.2 | 13.9 |
| 50–54 | 142 | 24 | 166 | 18.7 | 15.4 | 18.1 | 22.7 | 4.7 | 14.6 |
| 55–59 | 91 | 18 | 109 | 12.0 | 11.5 | 11.9 | 18.7 | 4.4 | 12.1 |
| 60–64 | 60 | 16 | 76 | 7.9 | 10.3 | 8.3 | 16.5 | 4.8 | 10.9 |
| 65–69 | 45 | 7 | 52 | 5.9 | 4.4 | 5.7 | 18.0 | 2.8 | 10.4 |
| 70–74 | 14 | 6 | 20 | 1.8 | 3.8 | 2.2 | 8.5 | 3.4 | 6.0 |
| 75 or over | 10 | 4 | 14 | 1.3 | 2.6 | 1.5 | 6.9 | 2.4 | 4.6 |
| Total | 761 | 156 | 917 | 100.0 | 100.0 | 100.0 | 17.3 | 3.7 | 10.7 |

Finally, by adjusting, in addition, for the urban-rural distribution, the excess of the rate for foreign whites over that for native whites was reduced to only 2.0 per cent, which is not statistically significant. In fact, the final adjusted rate for the foreign males was less than that for the native males.

Considering the major groups of mental disorders, it will be noted that the greatest excess in rates occurred in connection with dementia praecox, where the rate for the foreign-born was in excess by only 27.1 per cent, compared with an excess of 23.3 per cent on the basis of crude rates. On the other hand, the native-born had a significantly higher rate with respect to the alcoholic psychoses. The rate for the foreign-born for general paresis was in excess by only 1.4 per cent. Their rate for the manic-depressive psychoses was in excess by only 3.4 per cent. In neither case was the difference significant. In the remaining groups, the rates for the foreign-born were in excess by from 10 to 16 per cent, compared with corresponding excesses of over 200 per cent when comparisons were based upon crude rates.

The rates for the foreign-born males were less than those for the native males in the following groups of mental disorders: alcoholic psychoses, senile psychoses, involutional psychoses, manic-depressive psychoses. With respect to general paresis, the rate for the foreign-born was in excess by only 8.4 per cent. In connection with psychoses with cerebral arteriosclerosis, the rate for the foreign-born males was in excess by only 3.5 per cent. Only with respect to dementia praecox was there a significantly higher rate among the foreign-born males.

Interesting contrasts are presented when one compares the rates for foreign females with those for native females. In general, the rate for the former, when standardized for the three sets of variables, was in excess by 9.1 per cent. But the foreign-born females had lower standardized rates of general paresis and alcoholic psychoses, both of which are strongly affected by social factors. On the other hand, foreign-born females had a significantly higher rate for psychoses with cerebral arteriosclerosis. They also had higher rates for senile psychoses and involutional psychoses, whereas, the corresponding rates for foreign males were less than those for native males. With respect to the manic-depressive psychoses,

TABLE 12. NATIVE WHITE FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 20–24 | 12 | 2 | 14 | 0.8 | 0.7 | 0.8 | 0.8 | 0.1 | 0.4 |
| 25–29 | 73 | 24 | 97 | 4.7 | 8.9 | 5.4 | 5.1 | 1.6 | 3.3 |
| 30–34 | 167 | 48 | 215 | 10.9 | 17.8 | 11.9 | 13.1 | 3.6 | 8.3 |
| 35–39 | 281 | 40 | 321 | 18.3 | 14.9 | 17.8 | 26.2 | 3.7 | 14.8 |
| 40–44 | 273 | 36 | 309 | 17.8 | 13.4 | 17.1 | 28.7 | 3.7 | 16.1 |
| 45–49 | 247 | 37 | 284 | 16.1 | 13.8 | 15.7 | 30.6 | 4.5 | 17.4 |
| 50–54 | 219 | 40 | 259 | 14.2 | 14.9 | 14.3 | 33.9 | 6.0 | 19.7 |
| 55–59 | 115 | 18 | 133 | 7.4 | 6.7 | 7.4 | 23.8 | 3.4 | 13.3 |
| 60–64 | 82 | 18 | 100 | 5.3 | 6.7 | 5.5 | 20.8 | 4.1 | 12.0 |
| 65–69 | 55 | 4 | 59 | 3.6 | 1.4 | 3.3 | 18.2 | 1.1 | 8.9 |
| 70–74 | 8 | 2 | 10 | 0.5 | 0.7 | 0.6 | 4.0 | 0.8 | 2.2 |
| 75 or over | 5 | ... | 5 | 0.3 | ... | 0.3 | 2.6 | ... | 1.1 |
| Total | 1,537 | 269 | 1,806 | 100.0 | 100.0 | 100.0 | 10.4 | 1.8 | 6.0 |

the rate for foreign females exceeded that for native females by 7.9 per cent, though the excess was not significant. On the other hand, foreign males had a lower rate for the manic-depressive psychoses. Native females had a significantly lower rate for dementia praecox than foreign females.

TABLE 13. FOREIGN WHITE FIRST ADMISSIONS WITH ALCOHOLIC PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 25–29 | 4 | 1 | 5 | 0.6 | 0.6 | 0.6 | 2.4 | 0.4 | 1.3 |
| 30–34 | 34 | 5 | 39 | 4.8 | 3.0 | 4.4 | 10.7 | 1.4 | 5.8 |
| 35–39 | 67 | 19 | 86 | 9.4 | 11.4 | 9.8 | 13.7 | 3.9 | 8.8 |
| 40–44 | 99 | 28 | 127 | 13.8 | 16.9 | 14.4 | 17.2 | 5.2 | 11.4 |
| 45–49 | 138 | 21 | 159 | 19.3 | 12.7 | 18.0 | 22.0 | 3.8 | 13.4 |
| 50–54 | 136 | 26 | 162 | 19.0 | 15.7 | 18.4 | 21.7 | 5.1 | 14.2 |
| 55–59 | 106 | 27 | 133 | 14.8 | 16.3 | 15.1 | 21.7 | 6.6 | 14.8 |
| 60–64 | 75 | 20 | 95 | 10.4 | 12.0 | 10.8 | 20.7 | 6.0 | 13.6 |
| 65–69 | 38 | 10 | 48 | 5.3 | 6.0 | 5.4 | 15.2 | 4.0 | 9.6 |
| 70–74 | 13 | 5 | 18 | 1.8 | 3.0 | 2.0 | 7.9 | 2.9 | 5.4 |
| 75 or over | 5 | 4 | 9 | 0.7 | 2.4 | 1.0 | 3.4 | 2.4 | 2.9 |
| Total | 715 | 166 | 881 | 100.0 | 100.0 | 100.0 | 16.3 | 4.0 | 10.3 |

TABLE 14. NATIVE WHITE FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 35–39 | ... | 5 | 5 | ... | 0.3 | 0.1 | ... | 0.4 | 0.2 |
| 40–44 | 10 | 6 | 16 | 0.4 | 0.3 | 0.4 | 1.1 | 0.6 | 0.8 |
| 45–49 | 18 | 29 | 47 | 0.9 | 1.6 | 1.2 | 2.2 | 3.5 | 2.9 |
| 50–54 | 108 | 89 | 197 | 5.3 | 4.9 | 5.1 | 16.7 | 13.3 | 15.0 |
| 55–59 | 206 | 183 | 389 | 10.0 | 10.1 | 10.1 | 42.6 | 35.3 | 38.8 |
| 60–64 | 367 | 316 | 683 | 17.9 | 17.5 | 17.7 | 93.3 | 71.6 | 81.8 |
| 65–69 | 455 | 388 | 843 | 22.2 | 21.4 | 21.8 | 150.5 | 108.2 | 127.5 |
| 70–74 | 389 | 355 | 744 | 18.9 | 19.6 | 19.3 | 193.2 | 142.3 | 165.0 |
| 75 or over | 500 | 437 | 937 | 24.4 | 24.2 | 24.3 | 262.5 | 162.9 | 204.3 |
| Total | 2,053 | 1,808 | 3,861 | 100.0 | 100.0 | 100.0 | 13.9 | 11.9 | 12.9 |

It is obvious, then, that direct comparisons of rates of first admissions for the native and foreign-born white populations in New York State lead to spurious results, when corrections are not made for fundamental demographic differences. The foreign-born have a higher ratio of males to females, a higher proportion at advanced ages, and a higher proportion living in urban areas. Each of these tends to increase the rate of first admissions to hospitals for mental disease. We there-

TABLE 15. FOREIGN WHITE FIRST ADMISSIONS WITH PSYCHOSES WITH CEREBRAL ARTERIOSCLEROSIS TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 35–39 | ... | 1 | 1 | ... | 0.1 | * | ... | 0.2 | 0.1 |
| 40–44 | 4 | 3 | 7 | 0.2 | 0.2 | 0.2 | 0.7 | 0.6 | 0.6 |
| 45–49 | 25 | 27 | 52 | 1.2 | 1.6 | 1.3 | 4.0 | 4.9 | 4.4 |
| 50–54 | 148 | 85 | 233 | 6.9 | 5.0 | 6.0 | 23.6 | 16.6 | 20.4 |
| 55–59 | 275 | 192 | 467 | 12.8 | 11.2 | 12.1 | 56.4 | 46.7 | 51.9 |
| 60–64 | 402 | 344 | 746 | 18.7 | 20.0 | 19.3 | 110.8 | 103.2 | 107.1 |
| 65–69 | 473 | 375 | 848 | 22.0 | 21.9 | 21.9 | 189.2 | 150.4 | 169.9 |
| 70–74 | 384 | 302 | 686 | 17.8 | 17.6 | 17.7 | 234.2 | 175.4 | 204.1 |
| 75 or over | 442 | 386 | 828 | 20.5 | 22.5 | 21.4 | 305.5 | 236.6 | 269.0 |
| Total | 2,153 | 1,715 | 3,868 | 100.0 | 100.0 | 100.0 | 49.0 | 41.0 | 45.0 |

* Less than 0.05.

TABLE 16. NATIVE WHITE FIRST ADMISSIONS WITH SENILE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 50–54 | 6 | 7 | 13 | 0.6 | 0.5 | 0.6 | 0.9 | 1.1 | 1.0 |
| 55–59 | 10 | 18 | 28 | 1.1 | 1.3 | 1.2 | 2.1 | 3.4 | 2.8 |
| 60–64 | 45 | 64 | 109 | 4.7 | 4.7 | 4.7 | 11.4 | 14.5 | 13.1 |
| 65–69 | 93 | 163 | 256 | 9.8 | 12.0 | 11.1 | 30.8 | 45.4 | 38.7 |
| 70–74 | 193 | 257 | 450 | 20.3 | 18.9 | 19.4 | 95.8 | 103.0 | 99.8 |
| 75 or over | 604 | 848 | 1,452 | 63.5 | 62.5 | 62.9 | 317.1 | 316.2 | 316.6 |
| Total | 951 | 1,357 | 2,308 | 100.0 | 100.0 | 100.0 | 6.4 | 8.9 | 7.7 |

fore corrected for differences with respect to sex and age proportions, and this brought about an immediate reduction in rates for the foreign-born, the excess being reduced from 90.7 to 13.9 per cent. With one exception, the relative excess on the part of the foreign whites was greatly reduced in the major groups of mental diseases. The exception was dementia praecox. After correction for sex and age distribution, the excess of the foreign-born with respect to dementia praecox was increased from 23.3 to 38.4 per cent.

A further correction was then introduced to take account of a differential with respect to the relative proportions living

TABLE 17. FOREIGN WHITE FIRST ADMISSIONS WITH SENILE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 40–44 | 1 | ... | 1 | 0.1 | ... | * | 0.2 | ... | 0.1 |
| 45–49 | ... | 3 | 3 | ... | 0.2 | 0.1 | ... | 0.5 | 0.3 |
| 50–54 | 2 | 8 | 10 | 0.2 | 0.6 | 0.4 | 0.3 | 1.6 | 0.9 |
| 55–59 | 7 | 10 | 17 | 0.8 | 0.8 | 0.8 | 1.4 | 2.4 | 1.9 |
| 60–64 | 38 | 72 | 110 | 4.1 | 5.4 | 4.9 | 10.4 | 21.6 | 15.8 |
| 65–69 | 77 | 156 | 233 | 8.3 | 11.9 | 10.4 | 30.8 | 62.6 | 46.7 |
| 70–74 | 211 | 280 | 491 | 22.8 | 21.3 | 21.9 | 128.7 | 162.7 | 146.1 |
| 75 or over | 589 | 787 | 1,376 | 63.7 | 59.8 | 61.4 | 407.1 | 482.4 | 447.1 |
| Total | 925 | 1,316 | 2,241 | 100.0 | 100.0 | 100.0 | 21.0 | 31.4 | 26.1 |

* Less than 0.05.

TABLE 18. NATIVE WHITE FIRST ADMISSIONS WITH INVOLUTIONAL PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 25–29 | ... | 1 | 1 | ... | 0.1 | 0.1 | ... | 0.1 | * |
| 30–34 | ... | 1 | 1 | ... | 0.1 | 0.1 | ... | 0.1 | * |
| 35–39 | 3 | 19 | 22 | 0.6 | 1.8 | 1.4 | 0.3 | 1.7 | 1.0 |
| 40–44 | 47 | 162 | 209 | 9.9 | 15.7 | 13.9 | 4.5 | 16.7 | 10.9 |
| 45–49 | 76 | 289 | 365 | 16.0 | 28.1 | 24.3 | 4.7 | 35.3 | 22.4 |
| 50–54 | 142 | 265 | 407 | 30.0 | 25.8 | 27.1 | 22.0 | 39.6 | 30.9 |
| 55–59 | 114 | 166 | 280 | 24.1 | 16.1 | 18.6 | 23.6 | 32.0 | 27.9 |
| 60–64 | 50 | 84 | 134 | 10.5 | 8.2 | 8.9 | 12.7 | 19.0 | 16.1 |
| 65–69 | 35 | 34 | 69 | 7.4 | 3.3 | 4.6 | 11.6 | 9.5 | 10.4 |
| 70–74 | 5 | 8 | 13 | 1.1 | 0.8 | 0.9 | 2.4 | 3.2 | 2.9 |
| 75 or over | 2 | ... | 2 | 0.4 | ... | 0.1 | 1.1 | ... | 0.4 |
| Total | 474 | 1,029 | 1,503 | 100.0 | 100.0 | 100.0 | 3.2 | 6.8 | 5.0 |

* Less than 0.05.

in urban areas. After such correction, there were additional substantial relative reductions in the rates of the foreign-born as compared with those for the native-born. The foreign-born had lower rates of first admissions for the alcoholic psychoses, and the differences with respect to general paresis and the manic-depressive psychoses were so small as not to be signifi-

TABLE 19. FOREIGN WHITE FIRST ADMISSIONS WITH INVOLUTIONAL PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 30–34 | ... | 1 | 1 | ... | 0.1 | 0.1 | ... | 0.3 | 0.2 |
| 35–39 | 2 | 13 | 15 | 0.5 | 1.3 | 1.1 | 0.4 | 2.7 | 1.5 |
| 40–44 | 28 | 127 | 155 | 7.1 | 12.6 | 11.0 | 4.9 | 23.6 | 13.9 |
| 45–49 | 82 | 280 | 362 | 20.8 | 27.7 | 25.8 | 13.1 | 50.7 | 30.7 |
| 50–54 | 129 | 323 | 452 | 32.7 | 32.0 | 32.2 | 20.6 | 63.0 | 39.7 |
| 55–59 | 94 | 181 | 275 | 23.9 | 17.9 | 19.6 | 19.3 | 44.0 | 30.6 |
| 60–64 | 39 | 62 | 101 | 9.9 | 6.1 | 7.2 | 10.8 | 18.6 | 14.5 |
| 65–69 | 17 | 17 | 34 | 4.3 | 1.7 | 2.4 | 6.8 | 6.8 | 6.8 |
| 70–74 | 3 | 6 | 9 | 0.8 | 0.6 | 0.6 | 1.9 | 3.4 | 2.7 |
| Total | 394 | 1,010 | 1,404 | 100.0 | 100.0 | 100.0 | 9.0 | 24.1 | 16.4 |

TABLE 20. NATIVE WHITE FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 10–14 | 2 | 3 | 5 | 0.3 | 0.2 | 0.2 | 0.1 | 0.2 | 0.2 |
| 15–19 | 42 | 77 | 119 | 5.3 | 4.6 | 4.8 | 2.7 | 5.0 | 3.9 |
| 20–24 | 92 | 224 | 316 | 11.6 | 13.4 | 12.9 | 6.1 | 14.1 | 10.2 |
| 25–29 | 100 | 246 | 346 | 12.7 | 14.8 | 14.1 | 7.0 | 16.2 | 11.8 |
| 30–34 | 91 | 289 | 380 | 11.5 | 17.4 | 15.5 | 7.2 | 21.9 | 14.7 |
| 35–39 | 101 | 263 | 364 | 12.8 | 15.8 | 14.8 | 9.4 | 24.1 | 16.8 |
| 40–44 | 98 | 163 | 261 | 12.4 | 9.8 | 10.6 | 10.3 | 16.8 | 13.6 |
| 45–49 | 108 | 125 | 233 | 13.7 | 7.5 | 9.5 | 13.4 | 15.3 | 14.2 |
| 50–54 | 68 | 113 | 181 | 8.6 | 6.8 | 7.4 | 10.5 | 16.9 | 13.8 |
| 55–59 | 44 | 65 | 109 | 5.6 | 3.9 | 4.4 | 9.1 | 12.5 | 10.9 |
| 60–64 | 28 | 49 | 77 | 3.5 | 2.9 | 3.1 | 7.1 | 11.1 | 9.2 |
| 65–69 | 11 | 31 | 42 | 1.4 | 1.9 | 1.7 | 3.6 | 8.6 | 6.4 |
| 70–74 | 4 | 16 | 20 | 0.5 | 1.0 | 0.8 | 1.9 | 6.4 | 4.4 |
| 75 or over | 1 | 1 | 2 | 0.1 | 0.1 | 0.1 | 0.5 | 0.4 | 0.4 |
| Total | 790 | 1,665 | 2,455 | 100.0 | 100.0 | 100.0 | 5.3 | 11.0 | 8.2 |

TABLE 21. FOREIGN WHITE FIRST ADMISSIONS WITH MANIC-DEPRESSIVE PSYCHOSES TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 15–19 | 4 | 8 | 12 | 1.3 | 1.3 | 1.3 | 5.6 | 11.1 | 8.4 |
| 20–24 | 13 | 22 | 35 | 4.4 | 3.4 | 3.8 | 17.1 | 24.4 | 21.1 |
| 25–29 | 11 | 47 | 58 | 3.7 | 7.4 | 6.2 | 6.8 | 22.1 | 15.5 |
| 30–34 | 26 | 87 | 113 | 8.7 | 13.8 | 12.2 | 8.2 | 24.7 | 16.9 |
| 35–39 | 22 | 139 | 161 | 7.4 | 22.0 | 17.3 | 4.4 | 28.7 | 16.5 |
| 40–44 | 52 | 103 | 155 | 17.4 | 16.3 | 16.7 | 9.0 | 19.1 | 13.9 |
| 45–49 | 49 | 94 | 143 | 16.4 | 14.9 | 15.4 | 7.8 | 17.0 | 12.1 |
| 50–54 | 58 | 54 | 112 | 19.5 | 8.5 | 12.0 | 9.3 | 10.5 | 9.8 |
| 55–59 | 32 | 36 | 68 | 10.7 | 5.7 | 7.3 | 6.6 | 8.8 | 7.6 |
| 60–64 | 23 | 24 | 47 | 7.7 | 3.8 | 5.1 | 6.3 | 7.2 | 6.8 |
| 65–69 | 4 | 13 | 17 | 1.3 | 2.1 | 1.8 | 1.6 | 5.2 | 3.4 |
| 70–74 | 2 | 4 | 6 | 0.7 | 0.6 | 0.6 | 1.2 | 2.3 | 1.8 |
| 75 or over | 2 | 1 | 3 | 0.7 | 0.2 | 0.3 | 1.4 | 0.6 | 1.0 |
| Total | 298 | 632 | 930 | 100.0 | 100.0 | 100.0 | 6.8 | 15.1 | 10.8 |

TABLE 22. NATIVE WHITE FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 10–14 | 24 | 26 | 50 | 0.6 | 0.7 | 0.7 | 1.6 | 1.8 | 1.7 |
| 15–19 | 504 | 412 | 916 | 13.1 | 11.4 | 12.3 | 32.5 | 26.9 | 29.7 |
| 20–24 | 952 | 704 | 1,656 | 24.7 | 19.5 | 22.1 | 62.8 | 44.2 | 53.3 |
| 25–29 | 832 | 748 | 1,580 | 21.5 | 20.7 | 21.1 | 58.4 | 49.2 | 53.7 |
| 30–34 | 626 | 561 | 1,187 | 16.2 | 15.5 | 15.9 | 49.2 | 42.6 | 45.8 |
| 35–39 | 405 | 452 | 857 | 10.4 | 12.5 | 11.4 | 37.8 | 41.4 | 39.6 |
| 40–44 | 249 | 301 | 550 | 6.4 | 8.3 | 7.4 | 26.1 | 31.0 | 28.6 |
| 45–49 | 141 | 198 | 339 | 3.7 | 5.5 | 4.5 | 17.4 | 24.2 | 20.9 |
| 50–54 | 69 | 101 | 170 | 1.8 | 2.8 | 2.3 | 10.7 | 15.1 | 12.9 |
| 55–59 | 35 | 61 | 96 | 0.9 | 1.7 | 1.3 | 7.2 | 11.8 | 9.6 |
| 60–64 | 14 | 26 | 40 | 0.4 | 0.7 | 0.5 | 3.6 | 5.9 | 4.8 |
| 65–69 | 9 | 16 | 25 | 0.2 | 0.4 | 0.3 | 3.0 | 4.4 | 3.8 |
| 70–74 | ... | 5 | 5 | ... | 0.1 | 0.1 | ... | 2.0 | 1.1 |
| 75 or over | 2 | 4 | 6 | 0.1 | 0.1 | 0.1 | 1.1 | 1.4 | 1.3 |
| Total | 3,862 | 3,615 | 7,477 | 100.0 | 100.0 | 100.0 | 26.1 | 23.8 | 24.9 |

TABLE 23. FOREIGN WHITE FIRST ADMISSIONS WITH DEMENTIA PRAECOX TO ALL HOSPITALS FOR MENTAL DISEASE IN NEW YORK STATE, 1939–1941

| Age (Years) | Number of First Admissions | | | Per Cent | | | Average Annual Rate per 100,000 Population | | |
|---|---|---|---|---|---|---|---|---|---|
| | Males | Females | Total | Males | Females | Total | Males | Females | Total |
| 15–19 | 32 | 19 | 51 | 2.5 | 1.4 | 1.9 | 44.5 | 26.4 | 35.4 |
| 20–24 | 70 | 44 | 114 | 5.5 | 3.2 | 4.3 | 92.3 | 48.9 | 68.8 |
| 25–29 | 142 | 150 | 292 | 11.2 | 10.9 | 11.1 | 88.0 | 70.6 | 78.1 |
| 30–34 | 196 | 221 | 417 | 15.5 | 16.1 | 15.8 | 61.9 | 62.8 | 62.4 |
| 35–39 | 248 | 313 | 561 | 19.6 | 22.8 | 21.3 | 50.6 | 64.7 | 57.6 |
| 40–44 | 210 | 210 | 420 | 16.6 | 15.3 | 15.9 | 36.4 | 38.9 | 37.7 |
| 45–49 | 175 | 176 | 351 | 13.8 | 12.8 | 13.3 | 27.9 | 31.9 | 29.8 |
| 50–54 | 105 | 119 | 224 | 8.3 | 8.7 | 8.5 | 16.8 | 23.2 | 19.7 |
| 55–59 | 62 | 70 | 132 | 4.9 | 5.1 | 5.0 | 12.7 | 17.0 | 14.7 |
| 60–64 | 18 | 31 | 49 | 1.4 | 2.3 | 1.9 | 5.0 | 9.3 | 7.0 |
| 65–69 | 4 | 11 | 15 | 0.3 | 0.8 | 0.6 | 1.6 | 4.4 | 3.0 |
| 70–74 | ... | 4 | 4 | ... | 0.3 | 0.2 | ... | 2.3 | 1.2 |
| 75 or over | 2 | 4 | 6 | 0.2 | 0.3 | 0.2 | 1.4 | 2.4 | 2.0 |
| Total | 1,264 | 1,372 | 2,636 | 100.0 | 100.0 | 100.0 | 28.7 | 32.8 | 30.7 |

cant. Only in connection with dementia praecox did there remain a substantial excess of the rate of the foreign-born over that for the native born.

Foreign-born males had rates of first admissions which compared very favorably with those for the native born in all categories except dementia praecox. Foreign-born females, on the other hand, had higher rates than native females, except for general paresis and the alcoholic psychoses.

Two sets of conclusions appear to follow from these data. The more we compare the two populations on a comparable basis, the greater is the approximation in rates of first admissions. It is probable, therefore, that differences in rates appear to be a matter, not of race, but of certain environmental forces which weigh more heavily upon the foreign-born —forces which are related to the processes of economic and social adjustment. The fact that the rates for the foreign females exceeded those for native females in ratios that were higher than those for the males ties in with the fact that females generally find immigration a more difficult process than males. On the other hand, the continued relative excess of the foreign-born with respect to dementia praecox, even after the statistical adjustments, implies some fundamental difference. There is a belief to the effect that individuals with a schizoid temperament tend to migrate in larger proportion than the temperamentally normal population.[1] If this should prove to be so, it would indicate that a combination of such personal characteristics and difficult social pressures will result in relatively higher rates of dementia praecox. However, this does not imply an etiology based upon racial characters, but rather a combination of individual and social factors.

[1] See "Emigration and Insanity," by Ö. Ödegard. *Acta Psychiatrica et Neurologica.* Supp. 4, Copenhagen, 1932.

# THE RÔLE OF PSYCHOTHERAPY OF OFFENDERS: AN EVALUATION

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A COMMON denominator of offenders who come for treatment is that they are involved in some way with correction. The term correction, as we use it, embraces all the community's efforts in dealing with the offender after he is convicted and not in the narrower sense of prisons. It covers all aspects of rehabilitation, including prison, parole, probation, and other similar official facilities and services. Correction attempts to prevent recidivism both for the protection of the community and the welfare of the offender.

All offenders, then, with rare exceptions, are under some sort of civil or legal restriction. They have just finished serving a prison sentence and are on parole or are reporting to a probation officer. In both cases, the offender has to comply with the rules as stated in the parole and probation regulations governing his mode of living. Even those with only a criminal record, and no correctional supervision, are restricted in ways that set them apart from the average person. Certain types of criminal records, for example, prevent an individual from voting; getting a driver's license, except under specific conditions or limitations; and, in certain states, from working in a place where intoxicating beverages are sold.

Surprisingly, books and papers dealing with the treatment of offenders seldom devote much space to correction and, even when they do, it is lumped together with the laws and the courts, often in a derogatory manner. In order to correct certain misconceptions and place the field of psychotherapy of offenders in proper perspective and proportion, we will examine some of the highlights of the correctional picture.

About 850,000 persons are arrested each year for crimes

of one sort or another. Of these, 200,000 or so are very serious crimes, such as criminal homicide, rape, robbery, serious assault, burglary, and grand larceny. The rest include forgery, embezzlement and fraud, narcotics, sex offenses, drunkenness, and vagrancy, but do not include traffic offenses. About 70 per cent of the first figure are convicted and come under some correctional procedure, which means 600,000 offenders must be dealt with in one way or another: imprisoned, put on probation, discharged, or ordered out of the jurisdiction. Omitting traffic violators and drug addicts who voluntarily go to a hospital for treatment, there are about 600,000 potential offender patients who have been convicted of breaking the law.

The above figures have been estimated from the Uniform Crime Reports of 1952. They are in round figures only to indicate size and to serve as a comparison with the number of those treated by psychotherapy. The latter figure is very hard to arrive at because most reports are vague and unsubstantiated. We have to go by allusions in scientific papers and books, word of mouth, and our own personal experiences. The total number of offenders treated outside of institutions throughout the country annually is infinitely small; at a guess, two hundred or less in private practice, five hundred to a thousand in public agencies and institutions.

Not much mathematical skill is needed to determine the infinitely small percentage of offenders treated when compared with the total problem. Yet we have by now become accustomed to hear and read statements by prominent psychiatrists, psychologists, and social workers overzealously proclaiming that psychotherapy is the pre-eminent antidote for criminal behavior. Some even go further and say that all other methods are antiquated and should be immediately replaced by psychiatry and psychotherapy. These viewpoints may or may not prove to be true; it remains to be seen. But the attempt to establish a case based on such small samples is unscientific. Any demand to replace courts and prisons with diagnostic clinics and psychiatric hospitals is, to put it mildly, premature. Psychotherapy of offenders is still in its infancy, although showing every sign of growing and finding an important place for itself in the community's efforts to deal with offenders.

A widespread change in favor of psychiatric setups would

have to be more semantic than revolutionary. Whether a court becomes a diagnostic center or something else, it cannot function in any way that violates our constitutional privileges and political structure. Guilt or innocence must be legally ascertained. And when guilt is established, something obviously must be done about it. Whether we call it a sentence or period of treatment makes little difference to the offender or his custodians or supervisors. Extended treatment in an institution, mental or penal, under compulsion will be construed as harsh punishment by the offender regardless of what it is called, and he will have to be watched carefully to prevent his taking leave regardless of whether his keepers are called attendants or guards.

The lack of realism of many exponents of psychotherapy actually interferes with progress in introducing modern methods of treatment within the bounds of their capability. We are kidding ourselves when we imply that ignorance, prejudice, and unconscious resistance to change are the only or principal reasons for a general reluctance on the part of the courts and other official agencies to accept what psychotherapy has to offer.

We hear around the courts and correctional agencies the following general criticisms of the field of psychotherapy. Psychiatrists and psychologists, they say, are amateurs in the criminological field where a superficial knowledge is risky. We further hear that reports and recommendations from psychotherapists seldom are to the point or show any awareness of the real situation involved. Others complain that therapists are too likely to condone and make excuses for misbehavior. We can add to this the complaint that actually there are too few therapists or facilities ready to accept offender patients. These, then, are the real bottlenecks to the more widespread use of psychotherapy by the courts and correctional agencies. The lesson we can learn from these criticisms is that education is a two-way street and if we are to educate others to the value of a scientific method of treating offenders, we must educate ourselves in the ways of those in authority with whom we have to deal.

We must now backtrack briefly to locate the psychotherapy of offenders in its proper historical perspective. Modern thoughts and theories in handling the offender owe a great

deal to Cesare Beccaria who in a paper, "Essays on Crime and Punishment," published around 1765, brought forth two principles which are basic today: that crime must be considered as an injury to society and that punishment is justified only to the extent that it prevents criminal behavior. He was far in advance of his times because it took more than a hundred years after he wrote his paper to wipe out the cruel and inhuman punishments of that era. Indeed, the ideas of Beccaria pave the way for the modern approach of psychotherapy. We can follow the evolution through from retribution to reformation to rehabilitation, re-education, and the newcomer, psychotherapy.

For the last one hundred and fifty years, correction has dealt principally with prisons. Liberalization of correctional methods first took the form of making prisons more sanitary, and thus reducing mortality, introducing religious instruction and work programs, and finally providing facilities for academic and vocational education. Along with these reforms, living quarters were improved and better medical care provided. In recent years, mental-hygiene facilities have been introduced. In most cases, the mental-hygiene facilities still are scanty, often taking the form of one psychiatrist for five hundred to a thousand men. No genuine psychotherapy is possible under these conditions.

Probation and parole must be considered as the two most important and advanced methods of correction, representing the strongest tendencies today away from institutionalization, but with the threat of punishment strongly inherent in each. The offender is dealt with as an individual and an effort is made to remove some of his difficulties and help him to adjust socially and reintegrate in the community. Psychotherapy fits in with these methods as an auxiliary for cases where there is a clear-cut need. The chances of success with psychotherapy are strengthened when combined with either parole or probation.

Some over-enthusiastic adherents of psychotherapy may wince at hearing it called an auxiliary method, after supporting somewhat grandiose conceptions of its present-day importance. Yet to imply a wider rôle in crime prevention and correction distorts the picture. If for no other reason, the size of the crime problem prevents psychotherapy from

playing a larger part at this time. Even if we do not question the expense or effectiveness, where would so many therapists come from? Psychotherapy of offenders is a specialized field, actually requiring intensive training in correctional, criminological, and legal work, as well as in mental hygiene. So we are further limited in the number of workers we can get, because obviously it is not simply a matter of tapping current psychotherapeutic resources and moving them lock, stock, and barrel into work with offenders. The fact that not every psychiatrist or other mental-hygiene worker trained in therapy can treat offenders is a disappointment to many who assumed that conventional psychotherapy would automatically be suitable for offenders, giving us a somewhat larger reservoir of therapists to select from.

Psychotherapy under official auspices, as part of a correctional or authoritative agency, has made greater headway today than psychotherapy done privately. We find psychiatric and mental-hygiene clinics in correctional institutions, in courts, and sometimes even in the juvenile delinquency sections of police departments. They have won greatest acceptance in juvenile courts as part of their service, in correctional institutions for juvenile and adolescent offenders, and in some prisons. There have been various experimental mental-hygiene clinics in adult courts under the jurisdiction of the probation departments.

Some observers consider that the placing of psychological clinics within the various authoritative settings, such as in courts or connected with parole and probation agencies, is the soundest approach to providing mental-hygiene for offenders. They argue that the offender would be receiving treatment right at the source and that, in addition, the unwilling patient would feel under some sort of pressure to accept treatment.

We have said that psychotherapy of offenders cannot altogether be isolated from official correctional programs. They weave in and out of the lives of our offender patients. Since we assume that the goals of both are the same—the protection of the community and the rehabilitation of the individual—it is safe to say that the forces of correction can operate without conflicting with psychotherapy and vice versa. The question is: will they work more effectively integrated or separately? Our conclusion is that psychotherapy functions most

effectively independent of any authoritative setup: detached, but not isolated; working in the same direction and not at odds with each other; with cordial relations, although not identified with each other.

The idea of clinics in an authoritative setting conflicts with one of the basic requirements of treating an offender. Before any treatment can be begun, we must make contact with the offender and win his trust. The offender patient must feel entirely comfortable and have no qualms that any of his expressed thoughts might eventually be used against him. In an official setting, the possibility of putting his foot into something would loom too large in his mind to make him free and easy. Would it be possible for him to discuss, say, homosexual fantasies or hostility against certain figures in authority? In an authoritative setting the patient could not help identifying the therapist with others in the same setting. If he were on probation, for example, we would expect too much to assume that he would not identify the therapist with his probation officer and the court. This is not to imply that the probationer cannot respect and trust his probation officer, but this trust in the majority of cases is circumscribed by the officer's position. The therapist in such a setting is part of the team that has lately crushed and humiliated the offender, who would have to step drastically out of character, drop all his long-held beliefs, and revise every habituated reaction to place his full trust in a member of the authority team.

Furthermore the therapist himself cannot reasonably remain immune from the potential of his own status. We well know how troublesome and exasperating an offender patient can be. The therapist would need superhuman restraint not to use his power punitively. And what would he do if one of his patients was violating his probation by not reporting? First of all, it is unlikely the patient would want to get in touch with a therapist who would have his office in the same building as the probation officer; but if the patient did, would he turn him over to the probation officer? This is not a hypothetical case; it happens frequently in the treatment of offenders.

This should not indicate blanket opposition to psychotherapy of offenders in any authoritative setting, although we hold the situation is improved when there is a plain separa-

tion between authority and non-authority. In the community, a private setup is practical and convenient whereas in an institution, there is no alternative. The greatest merit in institutional therapy, whether individual or group, in our opinion, seems to lie largely in the area of preparation for release. Radical changes in personality that will enable the individual to function better on the outside cannot be expected; the growth of psychological strength depends on experimentation and testing in living situations, which are impossible in the artificial atmosphere of an institution. Undoubtedly psychotherapy in institutions is invaluable as a preparation for release, if it is followed through with therapy to cope with the unpredictable experiences on the outside.

The view that insistence on separation of authority from non-authority unwisely reinforces the delinquent's hostility to authority has been widely used against those who favor treatment in a private setting. This argument has been effective mainly because of the guilt aroused in those defending private treatment at being accused indirectly of encouraging or condoning delinquent behavior through identification with the beliefs of the delinquent. Actually, as we have seen already, there are practical as well as emotional reasons, both on the part of the therapist and the patient, making treatment in an authoritative setting uncomfortable. We can add a few more but first we will mention that we do not consider it a good argument that because an offender is hostile or afraid of authority, including the police, courts, and correctional institutions, for his own good he should be thrust into an authoritative situation in order to get used to it—somewhat similar to the cruel way of teaching a child who is afraid of water how to swim by throwing him in. Authority and institutionalization are necessary and effective parts of correction. Probation and parole, as we have already said, do a fine job. We are not against authority; but we are against treatment in an authoritative setting, if it is possible to avoid it.

Offenders, as a matter of fact, generally have had their fill of authority. Their life too often consists of cops and courts and prisons, and too often the only other things they know are bad hangouts and bad associations. A therapist in a

private setting can well serve as a link between them and the normal world. The therapist in a private setting can honestly and convincingly answer the unspoken but inevitable question in the mind of the offender: "Are you for me or against me?", without necessarily having to take sides. There is, moreover, something to be said for the anonymity of the private treatment. The offender, perhaps more than anybody else, resents any label of mental illness, which, by the way, impedes coöperation of inmates in an institutional program of therapy. An inmate will step cautiously to avoid being called a "bug" by other inmates. In a private setting the issue does not arise except between therapist and patient.

In all respects the private therapist has a freer hand and with this type of patient it is greatly needed. He can, in effect, create his own rules to fit the situation without having to answer to a regulation or a supervisor. One of the things frequently overlooked is that a double standard of laws applies to offender and law-abiding citizen. An offender on parole, for example, violates the terms of his release by getting married, and for this violation he can be returned to prison, but he is not breaking any law. An offender on probation may not drive a car without specific permission from his probation officer, and this can well be a violation of the terms of his probation, but it is not a crime. A therapist under an authoritative setting may be compelled to act, or at least feel very badly about not acting, when he learns of these violations of the rules; whereas the private therapist need have no feeling whatever about it and still not feel guilty of condoning criminal behavior.

Of course the private therapist should not assume that because his freer hand in most matters increases the effectiveness of therapy, therefore correctional methods are an unnecessary evil. Frankly, if it were not for the pressures that the police and correctional methods put on the offender, the therapist would not have his patient. Unfortunately, we have found that few offenders have a genuine desire to face up to their problems and come for treatment to be helped as the ordinary psychiatric patient does. The offender initially comes for a multitude of reasons but the least of them is the desire to change. One of the most potent reasons an offender comes is the desire of the offender to make a good impression

on his parole or probation officer. Just behind that is the object of eliciting the aid of the therapist in court. It may seem unsportsmanlike but the therapist should have no qualms about using outside pressures to the hilt, at the same time disclaiming any connection or even sympathy with these pressures. One must admit in all honesty that there is a little bit of two-facedness in this attitude, which we have found effective if used with good intentions by the individual correctional worker. Actually the active coöperation of the worker in an authoritative agency increases the chances of success, provided the patient himself does not become convinced that the worker, say his probation officer, is hand-in-hand with the therapist. The relationship between the correctional worker and the therapist is a very delicate matter, which will have to be discussed in detail elsewhere.

The connection between the attitude of authority and delinquent behavior is not clear-cut. What does the average law-abiding person think of authority and what is the relationship of his attitude and being honest? We find many of our friends and neighbors very distrustful of, some even hostile to, the police, for example. This does not seem to make them bad citizens. Others are rather frightened, some to the extent that they are even fearful of getting a parking ticket. Others are just indifferent and hardly seem to be aware of the existence of the police. What does this prove? We should reëxamine our theories relating delinquency to authority and find out exactly how they fit in. Respect of authority is not a precondition for giving up delinquent behavior. And, therefore, within the bounds of reason, one who criticizes authority is not at the same time encouraging criminal behavior.

Normally fear is a deterrent. Treatment does not necessarily have to aim to undo the fear as much as it has to make it function normally as a deterrent. Each case, of course, is and must be individual. A large number of offenders are helped under the present correctional setups and practices. Some of these offenders plainly are deterred because they are fearful of the consequences of further bad behavior; others are helped through the friendship and guidance of the correctional worker. And others are helped by factors in the community. In each of these cases authority undoubtedly was a positive factor. There are a number of cases, however, where fear

does not function as a deterrent, and sympathy and helpfulness do not win respect and coöperation. These cases should be referred for psychotherapy and the therapist must be allowed the widest latitude toward authority without being accused of softness or permissiveness.

The place of psychotherapy in the correctional picture is at present small though important. The object should be not so much to take over the field of correction as to provide service for those offenders ordinary correctional practices cannot reach. Psychotherapeutic services are in greater demand than there are therapists available. The correctional worker and his agency generally favor community participation in the rehabilitation of offenders and look hopefully to the development of a more scientific method of treating the more difficult offender cases.

# SENIOR CITIZENS IN COMMUNITY WORK

## A GERIATRICS PROJECT OF THE MENTAL HEALTH DIVISION OF THE VOLUSIA COUNTY HEALTH UNIT, FLORIDA

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THE Mental Health Division [1] of the Volusia County Health Unit, Florida, has been successful in organizing a volunteer group of its senior citizens to assist in meeting some of the community needs. This project grew out of an interest in geriatrics, but quickly assumed the form of a reversible reaction between workers and subjects. Daytona Beach, because of its excellent climate and pleasant living conditions, is frequently selected as a place for retirement. The 1950 census revealed that 30,187 persons considered the Daytona area their permanent home and constitute the stable population. Sixteen per cent of these are above 65 years of age. The percentage for the state is 8.4, the percentage for the nation 8.8. In addition, there is a half-stable tourist population—people who have retired from active work and consider Daytona Beach their winter home. These people spend six to eight months of the year in this area, returning regularly.

Challenged by the question of the Director of Public Health, "What are you doing for our senior citizens?", the Mental Health Division embarked on a program of exploring the psychological needs of these retired people. Soon it became evident that a systematic approach was needed. Questions

* The writer is indebted to Dr. R. D. Higgins, Director of the Volusia County Health Unit, Daytona Beach, Florida, and to the Health Unit Staff for encouragement and support of this project, which was carried through while the writer spent her sabbatical leave of absence from Duke University working in the Mental Health Division of the Volusia County Health Unit.

[1] The Mental Health Division functions as an integrated part of the Public Health work in Volusia County. It is concerned with the satisfying functioning, the optimum psychological well-being, and the greatest possible happiness of the county's population. It works with all age levels and attempts to assist with all types of problems and adjustment needs.

crystallized and pointed up the need for more careful investigations to avoid remaining on the fringe of the problem. There seemed to be much overlapping in programs and recreational facilities available to small groups only.

We decided that, first of all, we needed information on what was actually being done in the community for older people. Secondly, we felt that we needed to know what retired persons themselves wanted and expected within our community. What were their own wishes, desires, and personal needs?

We considered this second point of considerable weight in formulating any type of future program. We were keenly aware that frequently decisions were made for senior citizens and blueprints provided for their life and happiness without consideration for their very individual needs. While we appreciate the importance of adequate nutrition in the prevention of chronic disease and the disabilities of old age, we have little appreciation of psychological starvation—the lack of stimulation, of choice and decisions, of self determination. Mature people, highly organized and structured personalities, were frequently pressed into a preconceived pattern at odds with previous goals and life experiences. All too often this resulted in an unhappy withdrawal from activities rather than in the stimulation of invigorating interests. This seemed to contrast sharply with the care exercised in assisting children and young people in planning. With youngsters, a formulation of such plans was largely based on their own choice and decision, their preferences and interests were being considered at each step.

Mapping out the general structure of our new area of interest thus seemed the basis for any first useful steps. Only after a systematic inquiry into these two points could we draw conclusions in regard to needs and then offer further plans to the community. We talked informally with many older or retired people. On the basis of such preliminary explorations we expected to design and focus a questionnaire to be used with large numbers. During these informal interviews we frequently found that "being shut off from the community," "not having contact with younger people," "being restricted in mobility" constituted acute problems. The retired population living in Daytona Beach included an unusually large number of professional and trained people. We realized that

there were in this community unexploited resources in talent, wisdom, and experience.

Simultaneously, our work became more systematic. We developed a questionnaire to serve as the basis of structured interviews, supplying the data for our survey. Our Public Health nurses were ready to assist in the gathering of data. Their complete acceptance by individuals, families, and agencies in the community placed them in a unique position and provided us with excellent contacts and resources. However, in view of large numbers needed for statistical analyses of the data, we were certain that we required additional help. When we casually mentioned our problem to some of our retired friends, we met with a great deal of interest. They had made our project their own and were ready to help us develop it. In spontaneous enthusiasm, they offered active coöperation, and we proceeded accordingly.

As a first realistic step we decided on a series of weekly meetings with the purpose in mind to:

(1) Train our prospective workers in techniques of interviewing, thus achieving some standardization of method in collecting data.

(2) Get better acquainted with our volunteers and provide for variations in approach as well as for screening workers.

(3) Assist our volunteers to derive genuine satisfaction from their work and to incorporate mental health attitudes into their new activities.

The meetings proved to be as helpful and stimulating to us as they were to our volunteers. The very first ones were slightly structured. They began with a presentation of the aims and goals of our questionnaire. Later on, members of the group interviewed one another and soon discussion was taken over by the group. Objective suggestions and subjective expression of feelings were intermingled throughout the one-and-a-half hour period. The entire group participated in lively discussion. Meetings developed into active and dynamic group education and took on a resemblance to group therapy. Individual tensions were brought out and could be dealt with. The group met at the Health Unit in the room used for play therapy. Numerous questions arose from this setting. Play therapy, child development, emotional development, the relation of psychology to mental health, the rôle

of the psychiatrist in the clinical setting, remedial reading, delinquency, anti-social behavior, and emotional breakdown were some of the topics discussed within the first two months. Twelve persons belonged to the initial group: attendance at the meetings varied from eight to eleven people.

The questionnaire was being developed and tried out during this period. At the same time, several of our group became interested, and offered assistance with other projects as a result of becoming acquainted with the activities and needs of the Mental Health Division. We accepted with appreciation one person's offer to provide the dolls in our play-therapy room with new outfits—clothing more suitable for dressing and undressing by small hands than the commercially-available doll's clothing. This woman's work resulted in an admirable collection of suits and dresses for the entire doll family. Outfits were complete with every type of underwear, easily managed buttons and button holes.

Two other volunteers noted our flashcards and picture material used for remedial reading. They offered their talents, did some good lettering, and supplied us with pictures for reading tests. They collected clippings, cartoons, and, with their typing and their discussions, created considerable interest in remedial reading within our group. In addition, they carried this interest further into a widening circle of friends.

At this point, we decided to combine our efforts to assist older people with our efforts to assist teachers and children in the school system. We undertook to widen the range of projects available to our volunteers. Our Public Health Director suggested the name "Mental Health Artisan's Group" (MHAG). From then on, we proceeded systematically with screening, training, and guiding into appropriate channels the enthusiastic energy and efficiency suddenly available to us. The group expanded to eighteen members. For the next few months we kept it within these limits, but divided it up according to interests.

Many of our clinical cases required prolonged care. We had, for instance, several cases where need for tutoring, which neither school nor parent could supply, proved to be a contributing factor in maladjustment. We also were asked to put up a Mental Health exhibit for the County Fair, and we

had only pamphlets to supply and lacked appropriate materials for visual education. Thus we turned to our group for assistance.

This was a new enterprise for the Mental Health Division as well as for the community. We proceeded gradually in order to assure satisfactions on an untrodden path. Continued weekly meetings with the "Mhags" provided the framework for close coöperation, for self-expression, and for the opportunity to guide each person into the type of work best suited to his own disposition, needs, and interests. The meetings were educational, dynamic, therapeutic. Two special events, the Mental Health exhibit and a day's trip to two well-known homes for retired persons, furthered motivation and unification of the group.

The Mental Health exhibit was put up as a part of the observation of Mental Health Week. The Division had not had an exhibit in previous years, and we needed to start from scratch—to proceed from discussing to planning and creating. Our "Mhags" conceived and made all of the needed pictures, posters, and panels. They selected what seemed basic in healthy emotional development, evaluated ideas, decided on the what and how of visual presentation. They dressed dolls, provided shelves, arranged tableaux and cared for all the major and minor details that go into an enterprise of this type. The exhibit was prominently displayed in the town and was a great success. Panels and posters were ready for repeated use.

Another satisfying group experience was provided by an all-day trip for "Mhags" working with our geriatrics questionnaire. We visited two institutions, and saw the provisions made for older people by two of the outstanding groups in our state. The trip provided an abundance of material for discussion, focussed and deepened interest in work in geriatrics, and contributed to a feeling of identification within the group by enriching the common background.

Other projects with which we received substantial help were library work, tutoring, remedial reading, and work with gifted children. The latter two projects are continually expanding. One "Mhag," a retired librarian, busied herself cataloging our own mental health library. She proceeded to center interest on improving our public libraries. Finally, she took

upon herself much of the detail work involved in making the community aware of mental health publications.

For tutoring we selected those children who were as much in need of prolonged personal contact as they were in need of catching up with school subject matter. They came from schools where teachers were overloaded; the economic resources of their families were zero. Not every child could benefit from every "Mhag." We chose and assigned on the basis of age, sex, likes and dislikes, considering the satisfaction of the adult as well as the child. Tutoring was carried through on an individual basis at the Mental Health office for varying periods of time.

The remedial reading project was particularly successful. It developed from the spontaneous interest of the group. Preparation and study were necessary to work in this field. We organized a series of sessions under expert guidance. A highly trained specialized teacher, nationally recognized, volunteered her services and joined our ranks for this work. Being keenly aware of the needs and problems in this field, she shared experiences and methods with the "Mhags" and later supervised their work with children. At present, two school systems are greatly benefited by this assistance. "Mhags" also helped with project work for gifted children who needed stimulation and resources beyond what the schools could supply; geography, various kinds of collections, radio work, photography, languages, and art. One gifted boy wanted a chess partner; a girl wanted music lessons which her family could not afford; several girls wished to develop special skills in arts and crafts and handiwork. This was an experiment, a pilot project within the framework of one school. In this particular school, teachers had been interested in what might be done for gifted children. They had participated in a study group on the "Gifted Child" in the preceding year and were ready to turn theory into practice.

As our "Mhags" projects developed, we organized the Mental Health Division as a kind of clearing house, bringing together young people in need of special help and older people whose talents needed quickening—a psychologically oriented exchange of needs and resources, and a bridging of the gulf of years by object-centered interests.

The group in Daytona Beach had started informally in the

first weeks of March. Our first formal meeting was on March 27. Within three months of that date, we had given 60 hours of staff time to the project and had received 227 hours of volunteer time. It is worth noting that the volunteer time was utilized in specialized areas and was of immediate support to projects in which the staff members were engaged. The project as such had not been planned. It developed spontaneously out of perception of needs brought to the attention of mature and socially-competent people whose talents lay wasting.

Our group of volunteers was highly motivated. We took advantage of such motivation, but with the clear awareness that our relations were basically those of give and take. We kept in close touch with persons and projects. Whenever necessary we provided stimulation, gave time and interest of a staff worker. By individual planning and some guidance, by careful screening for attitudes and personalities, by matching of interests and projects we assisted in making the efforts of our "Mhags" rewarding. There was no doubt that their work was worthwhile. They saw their reward in quantitative and qualitative achievements, went from new insights to planning and doing, grew in the process, and branched out into activities far beyond what we had originally hoped for. Our own criterion was the satisfaction of adult, child and teacher.

Benefits from the project seem threefold:

(1) For the community: the utilization of community resources to meet community needs and a growing appreciation of the contributions of "retired" persons.

(2) For the "MHAGs": a redistribution of energy and strengthening of the ego.

(3) For the Mental Health Division: an effective way of meeting community needs and a realistic demonstration of the principle: *Mental health is everybody's business.*

# PSYCHOTHERAPY WITH FOREIGN STUDENTS IN A UNIVERSITY

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THE cautious emergence of psychiatry from the "insane asylum," the nineteenth century ghetto of medicine, into the community is an event of this century. The tools provided by dynamic psychiatry resulted in the expansion of private practice and the development of treatment-centered, rather than research-oriented, child guidance and adult mental hygiene clinics, and contributed to the significant change in emphasis within the psychiatric hospitals themselves, from custodial to treatment institutions. Lagging slightly behind these developments has been the entrance of psychiatric and psychological services into the university. Very early in this century, G. Stanley Hall suggested the idea of having a mental hygiene course and mental hygiene services in Clark University. Dr. Stewart Paton of Princeton, in 1910, proposed that every college should have a psychiatrist on the faculty. However, it was not until 1920 that Dr. Harry M. Kerns was appointed as a full-time psychiatrist to the United States Military Academy at West Point, and that Dr. Karl Menninger instituted a counseling system in Washburn College in Topeka, Kansas. According to Dr. Clements C. Fry, as cited in "The Rôle of Psychiatrists in Colleges and Universities," by 1950 there were 550 psychiatrists in the United States who did some work for the colleges, and of this number twenty-five devoted themselves full time to the college or university.[1]

One can readily understand the reason for this development. The interdependent or corporate character of our society suggests that the mental or physical breakdown of any one of us has implications, admittedly subtle but there,

[1] See *The Rôle of Psychiatrists in Colleges and Universities,* Committee on Academic Education of the Group for the Advancement of Psychiatry, Report No. 11, Topeka, Kansas, September, 1950, p. 1.

none-the-less, for the welfare of all of us. When one considers further the cost to society which the college-educated represent, and the further loss of high level service that is involved if the individual is unable to function adequately, we can understand the basis for the development of psychotherapeutic services within the university. According to the Committee on Academic Education of the Group for the Advancement of Psychiatry:

> "It is generally recognized that college graduates form a high percentage of the leaders in any community, and the more maturity they display in their leadership the better it is for the welfare of the community. The emotional health and maturity of this influential two per cent of our population who are enrolled in our colleges and universities thus becomes of prime importance. If educators and psychiatrists, together with workers in the related disciplines, can cooperate to produce a greater degree of emotional maturity in these college students, we may expect significant improvement in the approach to and solution of many of the social problems which the world faces." [1]

And further:

> "Those who drop out because of emotional stress may have the whole course of their lives changed in an undesirable way, causing a real loss to society in terms of educated service and citizenry. The college loses too, because often it has invested money, time, and effort in the student, which is partially wasted when his emotional disorder results in his having to give up the continuance of his college education." [2]

This individual and societal loss is even more pressing for the foreign student who is in this country at great cost to himself and his government, and who is often desperately needed in his native land due to their shortage of all types of professionally trained personnel. While it is unfortunate that the present level of psychiatric screening is such that only the more seriously disturbed may be detected with a high degree of probability, even this is unavailable since these countries are psychiatrically naive. And few employ any but academic screening devices in the selection, where there is selection, of students who are to be educated abroad. As a result, it is not surprising that these students frequently need help of a psychotherapeutic nature, without which their experience in this country might be most destructive to them.

This need for skilled guidance service for foreign students,

[1] *Ibid.*, p. 1.
[2] *Ibid.*, pp. 2–3.

including provisions for counseling of a psychological nature, has been underscored by the handful of articles which have been written in this field. The excellent study by a subcommittee appointed by the American Council on Education and the Institute of International Education deals primarily with the guidance of the foreign student in this country, and points out that "The average student from abroad feels the impact of his new environment far more than does the average American student on an unfamiliar campus," and feelings of homesickness may be accompanied by various psychosomatic complications.[1] Help from "qualified mental health authorities" may therefore be necessary. In this article, "Trends in Counseling the Foreign Student," Forrest G. Moore, foreign students adviser at the University of Minnesota, does not single out the need for psychotherapy, but certainly implies this in his description of the counselor-student relationship: "First, interaction must be taking place between the counselor and the student so that satisfactory adjustments to the student's problems are being made. Second, a part of counseling, of course, is the manipulation by the counselor of the environment to assist him in his task."[2] Clarence Linton, Adviser to Students from Other Lands, Teachers College, Columbia University, calls for counseling, including the psychological, due to the special needs and practical problems which foreign students have.[3] Theodore Hsi-En Chen, who had experienced the status of foreign student, calls for provisions for "friendly guidance" due to such problems as those arising in connection with harassment by immigration authorities and contact with prejudiced landlords.[4] In a questionnaire study on "Problems of Foreign Students" at the University of California, the students ranked the inadequacy of counseling services second only to getting acquainted with

[1] See *Counseling Foreign Students*, by Theodore C. Blegen, *et al.* American Council on Education Studies, Vol. 14, Ser. 6, No. 15, 1950, p. 23.

[2] "Trends in Counseling the Foreign Student," by Forrest G. Moore, in *Trends in Student Personnel Work*, by E. G. Williamson. Minneapolis: The University of Minnesota Press, 1949, p. 185.

[3] See "Counseling Students from Overseas," by Clarence Linton. *Educational and Psychological Measurement*, Vol. 8, 1948, p. 514.

[4] See "The Guidance for Foreign Students," by Theodore Hsi-En Chen. *Journal of Higher Education*, Vol. 21, 1950, pp. 126–131; 166.

American educational methods and standards. The authors conclude as their *first* recommendation of five:

> "More carefully planned counseling procedures are needed. The problems mentioned by the students are amenable to solution provided the students are given proper guidance and helped at critical moments. It is chiefly a problem of making adjustments to American educational, economic, and social conditions and to American attitudes."[1]

Dallas Pratt, reporting experiences in psychotherapy with the foreign student, points to the help which brief psychotherapy can be in the adjustment of foreign students to American life without "alienating their own important cultural values."[2]

The importance of providing skilled assistance in the adjustment of foreign students to this country is emphasized by Peterson and Riley, who found that many were embittered about their experiences in this country. They declare, ". . . in this hour of history, with war and peace, chaos and civilization, poised in delicate balance, we cannot afford to alienate a single friend."[3] This underlying idea is agreed to by virtually all writers in this area. After pointing out that foreign students return home to positions of leadership, Chen believes that "Through them it is possible for the United States to influence the course of events in other countries; through them it is also possible to develop much lasting friendship and good will."[4] That there is a certain naïveté in this point of view is suggested by the numerous examples of emnity by former students against the countries in which they received their education, indeed, even aided and abetted by the good educational experience which they had had. The leadership of the recent Indian revolution against England is an outstanding example of this occurrence, as is the Tito defection from the Russian bloc. While making friends who are likely to assume leadership positions in their native lands *may* be of value to this country, the above noted examples

[1] See "Problems of Foreign Students," by James A. Peterson and M. H. Neumeyer. *Sociology and Social Research*, Vol. 32, 1948, p. 792.

[2] See "Helping the Foreign Student in New York City: An Experiment in Brief Psychotherapy and Cultural Research," by Dallas Pratt. *Bulletin, World Federation for Mental Health*, No. 6, 1952, pp. 172–176.

[3] See "Foreign Visitors on American Campuses," by James A. Peterson and Frank Riley. *The Survey*, LXXXV (Aug., 1949), p. 431.

[4] Chen, *op. cit.*, p. 126.

suggest that the attitudes of national leaders may be more fundamentally based upon the nature and quality of the objective relations between states, and not upon mere subjective states of mind. Even if, as Linton says, "The greatest investment in peace must be in the minds and hearts of people," [1] the previously cited subcommittee of the American Council on Education points out:

> "Few students come to the United States primarily to learn the 'American way of life' or as 'unofficial ambassadors.' Coming to the United States for education is strictly a business and professional investment for most foreign students. Although these students are anxious for peaceful years in which to live their lives and do their work, few if any of them feel a special sense of mission to convert either Americans or their countrymen to a One World point of view. International friendship and good will may well result from their residence here, but to them their ambassadorial functions are merely by-products." [2]

What then may be a more realistic rationale for the provision of psychotherapeutic services for foreign students?

*The Rationale Behind Psychotherapy for Foreign Students.*—We believe that we are on sounder ground, if we base it upon these reasons: (1) from a species point of view, human beings ought to be assisted whenever and wherever necessary to function at an optimum level; (2) a sound education is an experience of great significance, and the academic success of the foreign student may depend upon the working out of problems for which he needs professional assistance; (3) the student's appreciation of his experience in this country will be colored negatively by his failure in school, and successful psychotherapy can prevent this unnecessary bias from occurring. Furthermore, to return to his native land having failed to reach his educational goal is an extremely trying experience for the foreign student, especially when he has been sponsored by his government. In that case, he feels that he has failed not only himself and his family, but his nation as well, and a strong urge for suicide is not infrequently the result; (4) there are special problems which the foreign student faces which increase his susceptibility to mental stress; problems which will be taken up later in this paper. If these reasons are sound, then the promise of continued growth in foreign student enrollment in institutions of higher learning, the

[1] Linton, *op. cit.*, p. 521.
[2] Blegen, *op. cit.*, p. 3.

paucity of material in the area of psychotherapy with foreign students, and the special value inherent in getting at the *distinctive* problems for which psychotherapists should be prepared in working with foreign students, make it imperative that more be known about this area.

*The Foreign Student Program at the University of Illinois.* —What do we mean by a "foreign student?" We are in accord with the definition offered by the Institute of International Education:

> "A foreign student . . . is a citizen of a country other than the United States who is studying or training in an institution of higher education in the United States, and who plans to return to his home country when his studies are completed. The term does not include Displaced Persons, immigrants, persons who have taken out first citizenship papers, or foreign citizens studying in the United States below the college level."[1]

At the present time there are approximately 63 nations represented at the University of Illinois. The bulk of the 587 foreign students in attendance come from the Near Eastern countries (130), China (80), Canada (70), India (60), and Colombia (55). The foreign student program originated in 1911, when indemnity money from the Boxer Rebellion was used by the United States for the purpose of bringing to this country students from China. This program, directed by a Dean for Foreign Students, was discontinued in 1926 due to the decline in foreign student enrollment. At the end of World War II, the resumption of more orderly relations between states made possible another influx into this country of foreign students. A majority came through the use of their own funds, but a significant minority were either partially or fully subsidized by their native lands or this country, with the expectation that they might better contribute to their home countries through the education which they received here. Part of this country's motivation has been ideal, that education will save mankind from war, poverty, crime, and the like; another part has been "strategic," that this usage of our advanced educational facilities might be a useful instrument in the struggle for men's minds, the struggle between the Western and the Communist nations having become obvious shortly after the end of World War II. In 1946, with

[1] See *Education for One World,* New York: Institute of International Education, 1954. p. 4.

57 foreign students on the campus of the University of Illinois, the office of the Dean for Foreign Students was reëstablished. In 1954 there were 587 such students, or better than a tenfold growth in eight years, while in the nation as a whole the increase in this period was from 10,341 to 33,833.

Responsible for this overall increase throughout the country are such agencies as the United States State Department and the Department of Labor, the exchange scholarships made possible by the Smith-Mundt bill, Fulbright travel grants, the projects of the Foreign Operations Administration, the support by foreign governments themselves, and the educational activities of such organizations as the Ford Foundation, the Commonwealth Fund, and others. The significantly greater growth in the number of foreign students at the University of Illinois, as compared with the national growth, is largely due to the early entrance of the University in making provisions for foreign students and its growing national and international prestige as a first-class institution. In addition, the University has made special efforts to welcome and attract foreign students through the Office of the Dean for Foreign Students, the efforts of other organizations within the University, and policy making by the University as a whole. Five years ago, the University published a special folder on the program for foreign students which is sent to anyone from a foreign country who is interested in attending this University. This folder provides such important and practical information as an estimate of the living expenses at the University, information about scholarships and fellowships available, the types of employment opportunities, and so on. The school provides 25 four-year scholarships, maintains close liaison with selected foreign schools, and offers graduate fellowships through the Institute of International Education, with which it coöperates closely. While there is much more that needs to be done, in its own small way the approach has been constructive. As a result, one is not surprised at the tenfold increase of foreign students since 1946, nor, consequently, at their more frequent appearance at the various guidance and psychotherapeutic agencies of the University.[1]

[1] Unfortunately, we are unable to compare the percentage of foreign students obtaining assistance of a counseling or psychotherapeutic nature with the normal population of students. This is because three different offices without a common set of statistical methods share in this responsibility.

*Some Problems of Foreign Students.*—The following cases, the summaries of which are presented, were selected on the basis of the problems having developed or been precipitated by the student's status as a foreigner. It is true, of course, that many had typical neurotic conflicts, but these are not included due to the lack of any distinguishing features from problems of native students. The problems, which come out of conditions judged peculiar to foreign students, are eight in number:

1. Changed political conditions at home.
2. Living at a distance from home in another country.
3. A course of studies prescribed by the government.
4. The academic pace of American educational institutions.
5. Belief in magical thinking.
6. Negative attitudes of Americans toward foreigners.[1]
7. The different character of American culture.
8. The use of foreign-student status to rationalize academic failure.

It should be borne in mind that these rarely appeared in pure form, as other problems of a situational or developmental nature are frequently complicated with them. A ninth category that might well be included is the difficulty that the foreign student frequently has with the English language. While at first glance this might not seem very significant, according to the Dean for Foreign Students, it has appeared that the mastery of English is one of the most significant variables in the foreign student's academic achievements. In one case the valedictorian of an Indian college suffered severe states of depression due to the crippling of his academic work on this account.

[1] The schizophrenic reaction of our own country to the presence of the foreign student is noteworthy. On the one hand, through governmental aid and the assistance provided by our private foundations, the foreign student is welcomed, and on the other hand, the reactions of some of our citizenry and the regulations of the McCarran Act, as one University official put it, make him feel like a "potential criminal." That the foreign student has been noted to have mixed feelings about this country is, therefore, not to be attributed exclusively to the peculiarly ungrateful nature of foreigners.

## 1. *Changed Political Conditions at Home:*

A. The student was referred by a doctor on the staff of the University Health Service due to his inability to get rest at night, and therefore not being able to complete his doctoral thesis. The patient was a thin, slightly built Chinese student of twenty-four years of age whose academic record was brilliant. He saw his problem as one of being unable to get down to work on his thesis, and this had been the case since he finished his preliminary examinations in March, 1952. (The student was seen during the Spring semester of 1953). He was only able to work about four hours a day since, although he slept enough, he did not feel rested when he awoke.

In exploring the situation with him, the following emerged as factors preventing him from working on his thesis:

1. His plan to return to China was in jeopardy. The Communists had taken over the country and he was extremely insecure about his status should he return to China, especially since his major field of study in this country was economics. He had a great deal of ambivalence about how to handle this problem.
2. In China the eldest son is supposed to marry first, but the patient gave permission for the younger brother to marry. When the brother married, the student's feelings of adequacy were threatened. Furthermore, the girl-friend he had in China had become engaged.
3. He felt inadequate in social situations. He saw himself as skinny, weak, and lacking athletic abilities. A Chinese girl whom he had been dating rejected him and "my pride was hurt." He was extremely sensitive about the gossip of the Chinese foreign student group on campus.

With supportive and interpretive help, the student began to participate more freely in social affairs. He came to a decision about his future plans, deciding to remain in the United States for another two years after graduation, and then to see how things were before deciding to return to China. Having made these decisions, he found his sleep to be more restful and extended his hours of work on the thesis. By the end of the semester he had completed his thesis and accepted a job in industry. He developed more insight about his social relations and wondered if he were not too authoritarian in a group situation. Since he was leaving the community, some material on group dynamics and democratic leadership was loaned to him. Months later, a Christmas card and letter of thanks, "for the confidence you stored into myself so that I could adjust into the environment with greater ease and smoothness," was sent to the therapist.

B. This patient was a middle-aged graduate student from India. He was seen during the Spring semester of 1948, having arrived in the United States in September, 1947. The student was referred to the Psychiatric Division for sharp chest pains, since a thorough physical examination had been negative. The patient indicated a fear of dying as a result of his "burning pain" in the chest.

The student's symptoms began early in December, 1947, during the period of great communal strife and slaughter in India between the Moslems and the Hindus. The student's wife and two children had had to

move four times to avoid being killed. Although his family was now in a safe area, his symptoms continued. By assisting the student to express himself fully about these worries, by interpreting the mind-body relationship and how he was in effect punishing himself for not having been able to help his family, the student rapidly improved. By the end of the semester all his symptoms had disappeared. Problems concerning his sexual adjustment in this country were also discussed and worked through. He expressed his appreciation for the therapeutic experience in this way, "The disease which was in my mind is no longer there. This will remain a very great remembrance in my life, the contribution of psychology to humanity."

C. The student was a second-semester sophomore from Bolivia who was majoring in mechanical engineering. He was referred to the psychiatrist by a physician who could not find any organic conditions to explain symptoms of "burning pain" in the stomach and constant tiredness for the previous two weeks. The student was short, alert looking, but seemed immature for his twenty-two years of age.

During the semester when he was seen (Fall, 1953) he was carrying half a normal load, and of the three courses he was taking he was passing only one. During his previous semesters he had maintained a "C" average, just well enough to stay off probation, with the exception of the Fall semester of 1952 when he did very poorly. During that year he had become upset due to the frequent revolutions occurring in Bolivia, and, as a result of the instability of the Bolivian government, the rate of exchange which used to be forty for one American dollar became two hundred and forty to one on the official exchange, and a thousand to one on the black market. His family was compelled to decrease their support of the student, and the compelling need for his going to work upset him.

Mind-body relationships were interpreted to the student by the psychiatrist. He accepted the idea that his tiredness seemed a convenient way to escape responsibility for the decisions which he had to make, and the hard work he had to do to succeed academically. He admitted that it would have been more convenient to return home for health reasons than to fail out of school. The stomach trouble appeared related to the fact that both of his parents had had stomach disorders, his older brother had had liver trouble, and the student had had an appendectomy last year, all of which had apparently sensitized him to this area. He admitted that he had been afraid of having ulcers like his father.

Having clarified his difficulties, the student focused on the problems confronting him and decided to stay on campus and settle down and work.

## 2. *Living at a Distance from Home in Another Country:*

A. The student was referred by a University Health Service physician for "nervousness." The patient, an under-graduate exchange-student from Germany, described his tension as beginning a few days before he came to the Health Service. He believed it began when he broke from an American girl-friend whom he had known for about a month. The reason he gave for doing this was that he could never take her to Germany, since he could not expect an American girl to adjust there. He thought that his depression and inability to study stemmed somehow from that event.

In evaluating what had happened in his split with his girl-friend, it

turned out that, instead of the patient having rejected the girl, she had turned him down, and this was partly what had upset him so much. She had been dating another boy at the same time as she had been seeing him, and she refused to discontinue her relations with the other boy. The student's vanity had been upset and, unable to develop the relationship any further, he took the final step of breaking if off altogether. It was very difficult for him to accept the fact that, in effect, she had been the one to reject his overtures. As to why the situation reacted on him to the extent that it did, it soon became clear that the student wished to remain in the United States, and the only way that he could do so was by getting married. When he saw that, at bottom, his relation to his girl-friend had been based on the desire to remain in this country, he was shocked. As he put it, "It is the truth, although I had not thought of it consciously." This seemed to considerably relieve the student, and by the time of the fourth and last interview he felt much better. He said that he was able to eat and to study again, and felt as if a great deal of pressure had been lifted off him. This easing of tension enabled him to take out this girl again and have a pleasant time.

B. This graduate student from Pakistan came to the attention of the Psychiatric Division in February, 1954, through the Dean for Foreign Students. The Dean had learned that he had been in his room for two weeks without eating, and he was apparently threatening to commit suicide. Before Christmas, the student had received a letter from his family stating that his mother was ill, and for him to return home. He did not wish to do so and remained in this country. Later he received a cablegram from home saying that his mother was dying and wanted to see him before she died. He decided to wait until the end of the semester examinations, but on January 20th he received another cable notifying him that his mother had died. It was at this point that he did not take the final examinations, and stayed in his room without eating.

When he was seen, a disturbed familial background emerged. Unfortunately, in the beginning phase of treatment he received a telephone call from his father who reprimanded him for his conduct. As a result of this call he took an overdose of sodium amytal, and this led to his being hospitalized in a state institution. The last report from the state hospital indicated that he was improving, and was making plans to continue his studies.

### 3. *Course of Studies Prescribed by the Government:*

A. The student, who comes from Afghanistan and is a second-semester sophomore in Agricultural Engineering, complained of an inability to concentrate on his studies. In addition, he was excessively tired; he would wake up in the morning, turn off the alarm and fall back to sleep, thus missing his classes. The picture he presented, generally speaking, was one of withdrawing from his academic work, a reaction which began with his first semester at the University of Illinois. At that time he had difficulty with his English classes, failed to appear for most of them, and failed the course at the end of that semester. Since that time he maintained a barely passing average in his course work. Because he was here on a government and Ford Foundation scholarship, he found it most

disturbing that he was not doing better work, which he believed that he could do if only he was able to study and attend his classes. An important factor which appeared to be part of the total picture was that the student was particularly interested in the study of physics and had done well in those subjects, but his government was compelling him to major in agriculture, a field for which he had little interest.

A physical and neurological examination was essentially negative. However, he showed numerous signs of anxiety during the physical examination, *e.g.*, his eyes watered intensely during the ophthalmic examination and there were tremors of the tongue and outstretched hands. The student, who had been looking for an organic explanation for his symptoms, then shifted to blaming the climate and geographical locale for his physical and academic problems. He had committed himself to Agricultural Engineering before coming to this country, and no change was possible in the type of scholarship which he had, due to the specific terms of the Ford Foundation and Afghanistan agreement. The student would not openly face the problem of his irresponsible behavior, nor examine the question of his academic capacity through psychological tests which were available to him. Consequently, collaborative planning was done through the office of the Dean for Foreign Student to keep him "in the field" instead of going along with his plans to escape by going to another school.

4. *The Academic Pace of American Educational Institutions:*

A. The student was referred by a Health Service physician due to his complaint of insomnia and "neck tension" for which there appeared to be no organic basis. He was a forty-year-old unmarried graduate student from Iran. The student's symptoms began with the commencement of his study for the Ph.D. degree in Agriculture. He was taking a full load and felt himself under a great deal of tension due to the course work. In addition, he felt the pace of academic life and life in general was much faster in this country than in Iran. Significantly, when he once worked in Teheran at a position with a great deal of responsibility, he had also suffered from insomnia.

The relation of emotional tension to physical tension was interpreted to the student. As the problem was discussed, the student saw that the factor of academic tension and the increased responsibility which he felt to get the work done, as compared with his last position in Iran, were the factors that were causing him to be sleepless. Exercise and other activities of a recreational nature were suggested to him. He agreed to try them, and if they did not work to drop a course in order to ease some of the academic load that he was carrying. He believed that if he went home he would not have this problem, but at the same time he did want to stay in this country and complete his education.

The student began to take off a day every week for recreational purposes and found that he felt and slept much better. Nine months after termination of treatment he was still on campus working toward his degree, and he reported that his insomnia was so infrequent as not to be a problem any longer.

### 5. *Belief in Magical Thinking:*

A. The patient was a graduate student in Engineering from Pakistan. Having been in this country one month, he was referred to the Psychiatric Division for insomnia in October, 1953.

The student had never had any difficulties until the Fall of 1950. At that time he had a dream that a man came to him and urged him to study much harder. Prior to this he had led what appeared to be a balanced school, social, and athletic life, but after this dream visitation he did nothing but study. Once he played soccer, but that night had another dream of swords coming at him, so he gave up all sports activities. His sleeplessness began with the threat-of-punishment dream. In the Fall of 1952, after two years of studying for fifteen hours a day, he suddenly lost the ability to read. Otherwise, his vision was undisturbed. The medical treatment which he received at that time was of massage and injections, and he recovered in three months.

A firm and authoritative interpretation was made to the student that no such being existed as this "power" which he feared, and that the dream was probably related to ambitions which he had for himself. A rapid and dramatic improvement occurred in the student. At the end of three interviews he had no further use for the sleeping capsules which had been prescribed for him, and he described himself as having been "born again."

### 6. *Negative Attitudes of Americans Towards Foreigners:*

A. This former student was referred by a physician because of insomnia and nightmares. He had just graduated from the College of Commerce, but did not wish to return to China because of the changed political situation in that country. Since his graduation, he had worked at a responsible office job which he liked very much.

His main complaint centered about the "bad dreams" which he was having, and which were responsible for disturbing his sleep. While he had been taking sleeping pills, these did not seem to have much effect. The principal type of dream which he had was of murdering someone, or of witnessing a murder, and then running away only to be caught by the police. Very often the person killed in the dream was a female. In tracing out the connections of this dream through the associations of the patient, it was learned that in the office where he worked one of the female employees was obviously discriminatory in her relations to him. She gave him work to do that was not his responsibility, and, if a mistake was made, she automatically assumed that the patient had made it. The patient's method of handling her was to try to be calm about the situation, and this meant that he pretended not to be affected. However, he admitted having been very upset when she did such things as lock him out of the office, and another time when she snatched vouchers out of his hand when he was assisting a client. It is significant that he described himself as having been very "hot tempered" as a child, and his temper had led to his being beaten many times by his mother.

He was able to use the interpretations made about the relation between the tension which he underwent at the office, his repression of his emotions, and the dreams of doing something violent to a woman. He was able to effect a transfer to another office where he had a better job and more

congenial employees to work with. During the three month treatment period the nightmares diminished considerably, and in the last month there was only one dream which disturbed his sleep.

### 7. *The Different Character of American Culture:*

A. This graduate student, an upper-caste Hindu, was referred by another Indian student who had been helped at the Psychiatric Division. He was troubled with pains in his hands and wrists, and this had first developed while he was on board ship traveling to this country. He recalled that he had eaten meat when for the first time, which had aroused in him "passionate feelings." The student was devoutly religious, a fervent admirer of Mahatma Ghandi, and had been leading a vegetarian and celibate life while he was in India. In this country, he had been advised by doctors, who had found nothing organically wrong with him, to eat meat, and that it was not responsible for his symptoms. He also believed that the way in which women dressed, and the greater freedom of relations between sexes aroused these feelings, but, in the main, he attributed them to eating meat. As he put it, "By taking meat, my ideas became passionate. When I came here I blindly took whatever came my way. I found myself passionate and distorted in ideas. I never went out with a girl, because this is not the custom in India. You do not touch a lady there. You may not look at a woman except as a sister. If I stayed in India, I probably would have been married, but I did not mix with girls there. I think that the passionate ideas are due mainly to diet." Indicative of the student's religious ideas about sex, he referred to nocturnal emissions (which embarrassed him greatly) as "nocturnal pollutions."

Therapy was directed at interpreting to him the normalcy of his urges, that man was so constituted that one aspect of his nature was sexual, and necessarily so. His hand and wrist pains were interpreted as symbolic of his sexual conflict, in that he was punishing himself for an urge to masturbate. The eating of meat, his first break from religious controls, was viewed as the trigger that set off these impulses which he had held back. In the course of treatment, the student began to accept these strivings of his and to read psychological literature dealing with his problem. His symptoms disappeared, and he even began to date with satisfaction.

### 8. *The Use of Foreign-Student Status to Rationalize Academic Failure:*

A. The student was a thin, self-effacing junior, in engineering, from Colombia. As he perceived it, his main problems were his poor ability in English and his lack of interest in his work due to familial economic problems in Colombia. He did not know whether to go home or to stay here, and an initial discussion of the problem indicated that the best plan was to stay on in this country and obtain his degree in engineering. Since he was on probation, and another failing semester meant his dismissal from college, he decided to confer with his instructors to find out how he was doing this semester. In the meantime, it was learned that he was failing three of his six subjects, and a telephone call to the Dean

revealed that he already had 23 hours of "E" and failed to show up for the final examination in 20 hours of course work. Throughout, his handling of his academic responsibilities had been disorganized, and this was noted also in his handling of appointments, since he was usually lax or forgetful, at times showing up a day later for his interview.

Since his academic record was so poor, it was thought advisable to check his intellectual capacity. A telephone call to the Student Counseling Bureau revealed that he had done very poorly in the mathematics part of the American College Entrance examination, although his overall intelligence seemed adequate for academic work. A re-test on the mathematics section of the American College Entrance examination, and a mathematics ability test was taken by the student, due to the importance of this ability for anyone in the engineering curriculum, and the difficulty that he had been having with these subjects in particular. Both tests were standardized on freshman students, required a minimum of linguistic ability, and still the student's performance was extremely poor. These findings were discussed with the student who believed this analysis to be correct, since even in high school mathematics had been his poorest subject. He began to think constructively of another academic plan, and decided that he would investigate bacteriology, for he did not believe mathematics to be as crucial in this field as it was in engineering. Since there were good departments in bacteriology at home, he decided to return to Colombia. Despite the fact that initially the student had resisted having to face his lack of mathematical ability as the primary cause of his academic difficulties, he was most appreciative for the help he had received once he had worked out his new plan.

While many more cases might be cited, these are sufficient to indicate the nature of the more frequent problems encountered in working with foreign students and how they were handled. It may not be unreasonable to conclude that the character of the experience these students have had in the United States has been significantly altered for the better due to psychotherapy. No doubt, the great problems of international relations are unsolved by so individualistic an approach, yet this may be the best that the psychotherapeutic fields can do. When therapy is successful, there occurs an experience of much meaning to the patient, and the changed conception of Americans which may come out of it is doubtless of a more favorable nature than that which results from certain other postures that we strike. In so far as friendly feelings toward this country on the part of individuals is of any significance to good international relations, this psychotherapy may effect. And the deep gratitude of the foreign student is at times movingly indicated, as in the following letter from student 1–B, received four months after the termination of treatment.

Sept. 21, 1948

Dear Dr. Jenkins: [1]

I write this to express my feeling of joy and gratitude to you and Mr. Otis for the services you have rendered in my case and helped one cause of humanity.

I, being a student from India, had varied difficulties during (last year) the first year of my stay here and had developed an acute pain in the chest last year. I used to think, on account of the papers that about 7,000,000 people in U. S. A. are suffering from the heart trouble of some sort or the other, that I had also become a victim to it due to the American way of living. You know from the case paper that I spent a good amount of money for medical care but to no effect and the idea was becoming deeper and deeper in me of heart failure and the non capability of American medical practitioners.

I approached you with this thinking and but for your able analysis of my disease and sympathetic help, I feel that I would have ruined myself. I am now surprised. Now I am healthy, cured, and leading a normal life.

You might be knowing the mental set up of an Indian family. It is one of devotion and dependency of the wife and children to the male member of the family and if I would have lost my life, you can imagine what a big loss it would have been to my dependents, I being married and having two children, who are wholly dependent on me, unlike the set-up of this country.

When I realize this situation, I feel very grateful to you, in that you have not only helped me but my dependents also indirectly a cause of humanity.

I have now realized the value of the knowledge of psychology; how it can help the cause of mankind.

Please convey my thanks to Mr. Otis also with best regards. Thanking you ——

In terms of our experiences, we believe that the welfare of the individual student, the interests of foreign governments, and our own educational institutions would be better served if foreign governments themselves established preventive mental hygienic measures, in so far as they are able.[2] These would include:

1. Research in the psychiatric and psychological evaluation of the emotional stability of the student, especially as related to his capacity to tolerate academic tension and a long stay away from home.

2. Planning with him for his stay in this country, and the careful investigation of the student's academic, familial, and

[1] The reference is to Dr. Richard L. Jenkins, Chief, Research Section, Psychiatry and Neurology Division of the Veterans Administration. At the time of the letter he was University Psychiatrist at the University of Illinois.

[2] In terms of the American educational scene, nothing need be added to the recommendations of the previously cited subcommittee of the American Council on Education.

financial competency to successfully pursue his proposed course of study.

3. Evaluation of his mastery of English, particularly as it relates to his academic field.

4. Analysis of problems which have been met by one's countrymen who have been students abroad, in order to better prepare future students.

5. Preparation of the student for meeting prejudice in Americans. If the student is totally unprepared, the shock produced upon him is much greater.

It would be most helpful to the foreign student who has failed if his family and officials within his native country extended a sympathetic and understanding attitude towards him. In a foreign land there are many sources of tension apart from academic work *per se,* and it must be expected that some otherwise academically competent students will not succeed.

# PEOPLE: PATIENTS, PSYCHIATRISTS, AND PARSONS

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WHAT is the function of the Protestant clergyman? It would be revealing to have graduate students undertake careful research among theological students, faculty, clergymen, and laity, as well as among men and women of other professions, and share with us their findings. It is possible that such researchers would find the belief that the Protestant minister's function, in order of current importance, would be described by his services of preaching, marrying, burying, and possibly baptizing.

But within many who are ordained, there is a knowledge about, and a feeling for, a quality of pastoral relationship with the people and families of parishes and congregations. While we believe many clergy have an awareness of this, and even though they may feel able to accept and to understand human beings, it is an open question as to how many laymen differ so radically in their understandings and feelings about the "Reverend" and his job, that many ministers are in minimum communication with these laymen. Absorbed by a kind of cultural and spiritual osmosis from the general Protestant mores, there would seem to be around the function and person of the modern Protestant clergyman a feeling that he is too "good" to be able to understand how mixed up and anxious are persons in such a day and in such a society as ours. Just as within the commercial world the symbol of the "self-made man" stands high in the list of gods worshipped and idealized, so within the shepherd's flock many of the sheep tend to idealize the clergyman out of any vital contact with their realities. Not only in China is "saving face" a personal problem! One wonders how much of this feeling may be the product of Puritan-Pharisee emphases, and how much finds its roots in a fear

of change which would follow upon facing Reality and reality. Is the god of the Puritan a part of this dilemma? How vitally, in the case of the modern Christian community, do clergy and laity alike *feel,* individually and in groups, the Presence of Him who "came into the world to save sinners."?

Most of us who are privileged to serve as chaplains to the mentally ill, do so in connection with concurrent ministry in a community parish. When "normal" parishioners fall mentally ill, what feelings must they have, stemming from the several cultural confusions mentioned above? Such patients have committed our culture's unpardonable sin: they have proven not self-sufficient. There are many, therefore, who identify as synonymous the need for extra-personal help, with utter failure. The sense of shame seems actually to carry divine disappointment in them. Their own clergyman is seldom asked for by them. Some patients confide, "He's such a *good* man. I am afraid he would be shocked to know I am here in this hospital and to learn about what I've done and how I feel. I guess he'd be entitled to tell me that if I'd had enough faith, this wouldn't have happened." The feelings of patients' families would seem fraught equally with this fear of "losing face" in connection with the appearance of mental illness in one of their members. And the feelings of fellow-parishioners run a close second!

Sharing part of his time in a parish and the remainder as chaplain to patients in a mental hospital, is both an advantage and a disadvantage to a clergyman. One disadvantage is that the chaplain may be felt by the patients to bring with his own ministry, as it were, the conventional attitudes imputed to many clergymen and other members of the community as outlined previously. The patient, if he has had at least a nominal activity with his home Church, will tend to relate (or will attempt to relate) to the clergyman-chaplain within the behavior patterns he feels are expected when the clergyman comes to call on him in his own home. The clergyman-chaplain should be aware of this when first he visits the patient in a mental hospital. Active within the communications during the first visit will be not only the usual inter-personal transactions when two persons meet, but as well there may be strong feelings of guilt and shame because of being seen by one of God's representatives in a "failure" situation. In a

generation which feels that one can do whatever he sets his will to do, to be found mentally ill is most surely a "disgrace."

On the positive side, the clergyman-chaplain may be seen as, and felt to be, a part of the healing "team" of the hospital. Depending largely on how the clergyman-chaplain feels about his own self, how aware he is of his own function to any person (no matter what the particular setting), his insight and understanding, he is able to convey to the patient a feeling that that person still has dignity, deserves and receives respect, and is loved and accepted as he is. The non-verbal qualities of his ministry will be at least as important as his ability to use the right words at the appropriate time.

Should the chaplain seek the advice and counsel of the patient's doctor? Should the chaplain try to learn about the diagnosis, prognosis, etc., before making the first pastoral call on the patient? This cannot be answered with one word. Much depends, again, on many inter-personal factors. Frequently it proves true that the chaplain's first contact is just as it would be were the patient at home and the clergyman would be calling on him when ill physically. The chaplain seeks the advice and counsel of the doctor usually when the patient's degree of disturbance is seen to be such as to find the chaplain feeling the need for expertness not in his possession. If the relationship with a given patient, over a period of time, begins to develop strong elements of therapeutic (or other) movement, it becomes the chaplain to share thoroughly and gladly with the doctor, what he (the chaplain) believes is transpiring, and then to request the doctor's evaluation and suggestion.

For many centuries, the mentally ill have been segregated from the general community. They were isolated, consequently, from many of the social institutions in the community. The last several years have been characterized by many efforts to reintroduce many such institutions to the mental-hospital community. This is part of an attempt to approximate the environment of the mental hospital to the environment of the general community. A part of this effort has been the movement toward the establishment of a religious community in a mental hospital which closely resembles that of the outside world. In view of this, the clergy are becoming more and more active in mental hospitals. The clergyman, because of

his efforts towards the spiritual welfare of the patients, is an important member of the hospital's therapeutic team.

However, as a member of this team he is faced with several problems which do not exist so intensely in his ministry in the general community. In order for him to function efficiently in the hospital, he must be aware of these. These problems exist in several regions. One region is that of staff inter-personal relationships. The minister must be aware, as he serves as chaplain, of all functions of each member of the hospital staff. He must be aware of his own rôle in relation to the rôles of others. This is true especially of the relationship between the clergyman and physician. (This matter is discussed in some detail, below.) Other problems arise because of the differences in the social structure of the patient-community from that of the outside world. The chaplain must have a keen understanding of the social dynamics of the community which is the hospital. The chaplain in a mental hospital must have considerable understanding of mental health. He must understand ways in which he may be of special value to the mentally ill. A major component of this is a thorough background in modern, dynamic medical psychology. We feel that the ministry in a mental hospital is quite different from the ministry elsewhere. We therefore feel that it requires special training in preparation so as to result in the greatest effectiveness in the special functions of the hospital ministry.

The relationship of the clergyman-chaplain to the physician has been referred to previously. Appreciation of this requires an understanding of the history of psychiatry and its relationship to the clergy in various historical periods. Zilborg presents an excellent, though brief, summary in this regard. As he points out, mental illness is considered as in the realm both of medicine and of religion among the Greeks. They felt some mental diseases were of the body, natural in origin and hence medical; while others were supernatural afflictions of the soul and demonic in origin, hence primarily in the realm of religion. In subsequent periods of history, mental illnesses were assigned completely to demonic afflictions of a supernatural type. Mental diseases were placed, therefore, completely out of the realm of medicine and under the jurisdiction of the clergy. Our present historical period has been characterized by a return to the concept of mental illness as a

natural disease phenomenon. Modern medicine treats the patient as a whole. The patient is considered an individual. Therefore, all illnesses which the patient has, regardless of the type, are considered as illnesses of that person and are, therefore, within the realm of medicine. Thus medicine has once more taken over jurisdiction of this field from the clergy. Because of this historical sequence, many people still tend to associate the clergy with medieval concepts of illness. This is somewhat distressing to dynamically oriented modern clergymen. This is even more distressing because there are a few clergymen who continue to identify themselves with the "evil" concepts of mental function. This small group is frequently extremely outspoken. Furthermore, such persons often consider themselves as speaking for all of the clergy of our day.

Some such clergymen are extremely anti-psychiatric in their orientation. Radio and television speeches are given frequently by such clergymen, attacking bitterly modern analytic psychiatry. It is most unfortunate when some listeners react to this by identifying such attitudes as those typical of all clergymen. This is certainly most unjustified. Thus it can be seen that clergymen may frequently meet with considerable resistance when entering the hospital. In contrast with the outside community where the mere fact that he is a member of the clergy frequently gives him respected prerogatives, the clergyman-chaplain in the mental hospital finds that he must earn his way. He must demonstrate actively to the hospital staff his awareness of the problems of the patients and the institution, and his ability to cope with them.

The mental hospital is in the charge of the medical profession; the patients are under the immediate care and charge of the psychiatrists. The chaplain at best attempts to coöperate, under the doctors' supervision, in ministering to the mentally ill. Herein lie several possible entanglements which will involve the personal and the professional attitudes of both doctors and chaplain. If each doctor and the chaplain has an informed respect for the other's person and profession, then the patients benefit accordingly. If, conversely, either physician or chaplain feels that he has "the answer"; if he feels that the other professional person "means well" but doesn't "really understand" the patient and what his particular profession can contribute and share, trouble ensues.

Reference has been made to the mental-hospital community and its marked difference from the general community. The hospital community is extremely confusing to a person who is unaware of its intricate social pattern. Relationships within the patient group, employee group, or the staff group, as well as the relationships among the groups, are extremely complex. The mental-hospital community represents an authoritarian one and is so structured, beginning with the superintendent and medical staff and descending gradually downward to the patient. The patient occupies an essentially dependent rôle. In the eyes of the patient, the staff members often appear to have omnipotence resembling that which the infant attributes to the parent. The chaplain must be aware of social forces operating in such a community and how these differ from the corresponding forces in the general community. It is only through such understanding of the mental-hospital community that he can appreciate the potentials of his own rôle in the mental hospital.

A Protestant clergyman who was described as "painfully pious" was appointed by his denomination to visit members of that group who were patients in a large metropolitan mental hospital in another state. He was seen always with Bible and Communion kit, plodding daily up and down the various halls and in the many wards. In terms of the number of hours he spent visiting, he gave service way beyond the line of duty. He declined conferences with any of the doctors or social workers, who attempted to assist him, saying that he was so busy "taking the Word" to the patients that he had no time for "meetings." He opined that it was too bad that the Christian Churches had not seen to it that "Christians could be cared for in Church hospitals and not just 'dumped' in with anybody and everybody." The patients seemed to tolerate his ministry, especially the older women. He appeared to cater to those who responded to his frequent habit of hand-holding and benign smiling.

One day he was invited to share in a seminar with an analyst who discussed emotional development during childhood and adolescence. He listened to the analyst restively, said he had no questions, voiced no opinions. He was invited to return the following day for a completion of the seminar, but he failed to reappear. A few days later, some of the seminar

members ran into him on one of the wards and said they had missed him. He replied that he couldn't waste his time "like that" because "so many of the Christians here are hungry for Holy Communion." He added that it was too bad that we were born so late in time; that the golden era had been that in which the clergy looked after the sick "in the Name of Jesus, without having all these doctors and social workers meddling in what is the Church's business."

The personal feelings of both doctor and chaplain concerning religion become involved, too. The professional questions of status are inherent. And then there is present always the semantic problem: the languages of psychiatry and of religion. How is "grace" related to "insight"? Are "guilt feelings" and "sin" the same thing? Is Christian "redemption" the same as "adjustment" or "growth"? What are the standards by which to evaluate "adjustment"? Is religion an "illusion" or does it deal with "Reality"? Is prayer just wishful thinking? Their own beliefs and feelings and practices will condition dynamically the rapport of both doctor and chaplain and will affect their individual and team treatment of the patients.

Further, the understanding of the chaplain as to the basic concepts and approaches of the psychiatrist will affect his ministry to the patient in the mental hospital, as well as his relationships to, and ability to coöperate effectively with, the doctors. Here, a little knowledge may prove a dangerous thing. Psychiatry, like religion, can be oversimplified. The scientific aspects of both fields demand adequate education and disciplined training, preferably under supervision while treating and ministering. It has been interesting to observe with what enthusiasm numbers of theological seminaries and students, as well as ordained clergymen, have embraced their understanding of the so-called "Rogerian" approach to psychotherapy, some stating flatly, "It's a short-cut; saves lots of time; produces the same results without the necessity of going back and stirring up lots of muck." One sees many instances of the tendency to oversimplify psychiatry in theological circles, and unawareness of the tremendous medical-social-psychological funds of knowledge which have been developed, and which continue to grow yearly. An unmet need between the two professions is for adequate opportunity to communicate, personally, and through actual teamwork treat-

ment, followed by evaluation and planning for given patients. Members of both professions *are* busy and often say so. But the unmet need continues. It is reflected most seriously in the few actual case presentations in the literature wherein both psychiatrist and chaplain minister to particular patients simultaneously and report their progress, their failures, and their questions.

The chaplain should find his basic relationships with numbers of mental hospital patients in and through the worship services which he conducts, usually each week. The Protestant chaplain will need to know the similarities and differences between and among the several Protestant denominations, for these will lend him knowledge as he leads worship and when he preaches and works with groups. Along with whatever material the chaplain presents through his sermons, a major factor as to his effectiveness will be the communication of his own personal attitude toward God, toward others, and toward himself. To line out in words something of the content of this difficult-to-describe but nonetheless dynamic quality is a task more comprehensive than can be dealt with here. The chaplain's own belief and feelings about the power and function of prayer, the purposes of worship, the ministry of The Holy Spirit, the relevance of The Holy Scriptures, the Sacraments—these will affect all he says and all he does and all that he is, as he leads in the worship of God. The chaplain should remember and feel that patients in a mental hospital are still persons, not "cases." If he has emotional reservations about this fact, he had best seek profesisonal help with them for here, as in other relationships with the persons who are patients, his own attitudes and feelings will help or they will hinder.

It is not possible to overemphasize what happens if and when psychiatrists come to join in the worship of the mental hospital community. If they remain "the doctors," that's one thing. If, on the other hand, they come to offer their own worship, that's quite another. If the doctors never appear in any worship service, this affects spiritual morale much more than lip-service from them concerning their verbal "approval" of religion and of the religious ministry. It would be an interesting research project to study this whole matter within the field of group dynamics.

The knowledge of group psychotherapy continues to grow. Here is a developing edge with great potentials for psychiatric-religious coöperation. It would be interesting, too, to conduct Bible classes on a group therapy basis, having in one group the chaplain as the leader with a psychiatrist as recorder, and vice versa.

There would seem to be at least two points of view about the relationship of the mental hospital chaplain to the patients to whom he ministers. Some chaplains would seem to feel that so long as a patient is in the hospital, that patient is a member of his "parish." If this is the belief and feeling of a given chaplain, then the chaplain will make minimum effort to relate the given patient to his home clergyman and congregation. While some parish ministers seem almost happy with such a practice (because it relieves them of what they may feel is a difficult ministry?), this procedure finds a piece-meal approach to the total ministry of the Christian Church. This is over-specialization at its very worst. Within the tradition and concept of the "parish," it is essential for the pastor to be with his people both in joy and in sorrow. The chaplain should make every effort to keep in touch with his fellow-ministers in the general community, encouraging them to visit members of their parishes who happen, at a given time, to be patients in the mental hospital community.

The home parish's interest in the patient can be a therapeutic factor, rightly administered, and the home parish pastor can, in instances, bring with him some of the laymen of his local congregation, all of them representing the continuing love and care of the Church at large and of their parish in particular. Such continuing relationships afford the patient at least a taste of "normal" living. They keep him in touch with news about his family and friends, news heard through the lips of non-relatives. The patient feels that he is not "forgotten"; realizes that the religious community of which he has been a member, and still is, understands his illness and cares about him; that he still "belongs." Remembrances and cards on his birthday, important anniversaries, etc., and at seasons such as Christmas and Easter, can be shared with him by his own parish family. Then, too, when the patient is ready to leave the mental hospital and return to his home, often there is the practical matter of earning his daily bread, sometimes

of different living arrangements. Here the local congregation and pastor are afforded an opportunity for applied religious witness. If the community clergyman has visited the parishioner while the latter has been a patient, the patient knows that he "knows." Once back in the general community, the ex-patient has someone to whom to turn should things become disturbing, and the local pastor can coöperate intelligently with the hospital staff (and with any local clinic to which the ex-patient may be reporting) because of his contacts during the hospital experience. Through such experiences, one of the long-range results will be that local ministers and congregations will become more and more informed about the mental hospitals of their area, aware of their needs and problems, and informed enough to assist in the important aspects of community mental health.

*Summary.*—We consider the position of the chaplain in the mental hospital of tremendous potential value. However, it is our feeling that this position demands considerable background. Although we are somewhat encouraged by recent trends toward "clinical pastoral training," we feel a program far more intensive than any with which we are now familiar will be required to give the future chaplain adequate background and preparation to handle the total responsibilities of this important opportunity.

# PSYCHOTHERAPY WITH AGED PERSONS: PATTERNS OF ADJUSTMENT IN A HOME FOR THE AGED *

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IN an institution for the aged a psychiatrist is often called upon to help with so-called maladjusted individuals. These "maladjusted" persons may or may not be differentiated from the clearly psychotic or otherwise specifically mentally ill. To categorize an individual as maladjusted, although useful at times, is misleading because all adjustments are the inevitable outgrowth of the individual's past, his present circumstances, his view of the future and the real opportunities. Various methods of psychiatric therapy have been evolved to modify the adjustments in an individual's adaptive process. The variety of theoretical approaches from which successful techniques grow indicates that therapy does not require knowledge of the ultimate truth about human development and behavior. What are required are working concepts that provide a fulcrum and lever to make possible a shift in behavior. The behavioral shifts aimed for are usually determined by the needs of the community, the person treated, and the therapist. The therapist's need to help or heal, by present community and patient standards, should not be intrusive and should remain a reasonable response to the patient's and community's needs. The patient's needs may be generalized as relief from suffering, the reduction of social friction, the establishment of productivity, and the capacity to achieve satisfactions with relative flexibility and freedom of action. Community needs are highly variable; they differ with the place or setting and with the times. There is often considerable discrepancy between needs as experienced and needs as observed in community, patient, and also therapist.

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Community agencies and community attitudes may be such that there is failure to recognize individual requirements for satisfaction, and individuals may fail to recognize their own needs or to properly evaluate them. The awareness of frustration, resentment and anxiety in others or in one's self varies markedly with the perspicacity, sensitivity and discriminatory skills of the observer.

Residence in a Home for the aged is modification of an individual's way of life in response to a need. This modification is intended to be therapeutic or helpful. It is a societal response to community and individual need. A discussion of patterns of adjustment in a Home must therefore consider at least these items: the setting or Home itself and its place in the larger setting or community; the individual as more or less unique even though he be a member of a delimited age group; and the standards, methods, or criteria of adjustment evaluation.

*The Home's Place in the Community.*—The Home's view of itself and of its place in the community requires consideration of what people it attracts or repels, refuses or receives, and why it does so.

The Home, as a segment of society, regards itself as promising protection and gratification to people in need by means of its accommodations, supervisory care, medical care, dietitian-planned meals, its opportunities for socialization, work and play. The implications of this provision for protection and supervision may be immediately repellent for many older persons; many others cannot be considered in need of them. We know that social pressures, world-wide or local, such as wars and the displacement of persons, income taxes, inflation, and low pension or governmental assistance rates, limit the ability of the individual to provide for his old age and are among the direct or indirect reasons for his appeal to a Home for residence and care. We are also aware that inadequate housing and discrepancies between earning capacities as compared to desired standards of living may often cause children to work and live in such a way that they seem to neglect their aging parents. Aging persons who have lost economic and social resources and cannot reëstablish themselves because they have decreasing usefulness in industry; who are little

needed in the compact electrified home and have small value now as purveyors of tradition or entertainment in our age of public education, cinema, video and radio; or who are disabled for conventional productivity or utility by physical illness or emotional disorder, are viewed as needing the care available in a Home. What we are less often aware of is that aging persons with lifelong character disorders, psychoneuroses, and even psychotic trends or overt psychoses, tend to drift toward or be propelled to a Home as age adds its weight to their inefficiency.

Applicants to the Home, at least those seen by the psychiatrist, are for the most part the dependent, isolated or burdensome generators of frustration, anger, guilt, despair, and shame in their children, grandchildren, and assorted friends and relatives, and are the frightened or resentful searchers for protection in a state of subjectively sensed helplessness. They are in an emotional turmoil in which fear, anger, shame, and guilt are interwoven around a depreciated view of themselves to which physical illness usually adds significant portions. To the friends and relatives of these people the Home appears to promise relief from the burden of care or from guilt from neglect. The aged person may view the institution as a solution to financial, social, and medical problems, but has many reasons to resent his need for help as well as those who cater to it. Thus, it seems inevitable that the Home receives persons who have lost resources: economic, social, physical, and often mental. People with adequate resources do not gravitate toward the Home and the Home does not regard them as in need of its care. In fact, "aged," it seems, may soon be defined in terms of such loss of resources rather than chronologically. We may yet devise a scale to denote age in gradations of the harshness of fate, mistaken self-arrangements, genetic physiological contributions to decay, and the density, extensity, intensity and duration of assaultive lower biological life forms, mechanical agents and their by-products, encountered in the lifetime. The psychiatrist in his evaluation of the patient tries to do this. In the psychiatric interview of an aged person he assays what has been propelled or pulled through the selective screen, evaluating the person in terms of the social background, the family setting both past and present, and the present physical, emotional and psychological status.

*The Home Setting.*—A Home is usually far from being a homogeneous institution. The institution wherein these observations have been made houses about 870 residents in two main units. One hundred and forty persons reside in rooms, 107 in dormitories (rooms where continuous group supervision is available), and 121 in an infirmary (actually a small hospital), in one of the units. In the other unit, 154 persons reside in two hotel-style apartment houses, 167 in rooms, 108 in dormitories, and there is a permanent infirmary population of 65. The facilities of the two major units of this illustrative Home are therefore organized so as to permit the admission of persons who are relatively sound mentally and physically to living facilities (the apartment projects) which require personal strength and responsibility such as is required in the outside community, who may later be transferred to less taxing environments where there are increasing amounts of supervision and care should they decline physically or mentally. Acceptable applicants may be admitted directly to the units where it seems that their needs can best be met; the decision is made chiefly on the basis of medical and social service staffs' evaluation. Psychiatric information is requested with increasing frequency for help in deciding about place of residence. In all the units the available facilities and the organization of staff are intended to encourage self-reliance of every kind. There are aids toward participation in work, hobbies, group socialization, club participation, and religious worship. Complete medical care is provided in addition to the routine board, room, and physical assistance. There are movies, radio, television, periodicals, library, and diverse recreational facilities. The supervision is of variable degree ranging from that of a "housemother" type in the apartments through custodial nursing care in dormitories to complete nursing care in the infirmaries. Also, each resident has a social service worker who in many respects acts *in loco parentis.* All this places within the reach of every resident a number of responsible and skilled staff workers who are of continuous or potential aid to him in the solution of social and physical problems.

For the resident then, the Home has a variety of living arrangements, a potentially complex social structure and offers psychotherapy in a "total push" program by means of the direct counselling and guiding services of social workers

and the intuitive or planned attitudes of other staff members with the guidance of physicians and psychiatrists. The latter, at least, is the underlying intent and the outward form of the Home as it sees itself and tries to be.

*The Individual in the Home.*—Let us briefly now consider the resident: The sample of residents seen in the past four years by psychiatrists in the Home includes about 600 residents and 100 applicants for admission. Of the residents seen, more than 175 have been in psychotherapy and a fair percentage of these have been followed for a full four years. The majority of our patients were in the eighth to ninth decades; the youngest was 63 years of age. With one or two exceptions, all were Jewish. There were about equal numbers of relatively recent "refugees" who left Europe in the late '30s or when they were already advanced in years, and of "immigrants" who came to the United States when in their teens or early maturity. The number of native-born Americans was smaller. These proportions roughly parallel the makeup of the total Home population. The life experiences of these persons differed widely in detail but all lived within a cultural framework familiar to us all as "western," in which monogamy, the family unit, early implicit or direct sexual terrorization, essentially good infant care, the equation of mother or parent with food and protection, the rôle of father as the nominal head of the family, emphasis on obedience to parents in childhood, acculturation by way of rewards and punishments, emphasis on early toilet training and certain forms of cleanliness, and the evaluation of "success" in terms of prestige and power, (for both of which money or wealth is the conventional symbol), are all so important in individual growth and development.

The patients selected for psychiatric study by agents of the Home other than the psychiatrists were largely chosen because they constituted problems of management. Argumentative, rebellious, demanding, complaining, relatively immobilized, actively or passively sabotaging, querulous, openly depressed, suicidally inclined or threatening, assaultive and abusive residents were the most common referrals from the doctors, nurses, social workers and administrative officers of the Home. For a resident to refer himself because of suffering was a

great rarity. It is thus a part of the pattern that residents who provoke anxiety or resentment are most commonly referred; patients who merely suffer, who have problems that do not arouse enxiety or resentment, who do not require that they or those around them be protected, who perhaps provoke pity, compassion, or seem to need straightforward rational counselling, are not often referred to the psychiatrist in the Home. However, once referral has been made, a fair proportion spontaneously continue to seek out the psychiatrist and to perpetuate the interviews.

*The Evaluation of Adjustment.*—This brief and decidedly incomplete review is enough to reveal that the psychiatric team working in the Home finds itself surveying an organization which both intuitively and by plan is a psychotherapeutic institution on a grand scale. It offers a "total push" program, protection, medical care, adequate nutrition, occupational therapy, graded degrees of responsibility, individual counsellors, and group projects. The psychiatrist's measure of the adjustment of residents in the Home is consequently, willy-nilly, not only a measure of the resident but also of the Home. The psychiatric orientation he advocates must come not only from his own special training and experience but must necessarily consist of verbalization and reformulation of what he has learned in the Home and discovers to be successful or psychotherapeutic, as opposed to psychonoxious. In his evaluation of patterns of adjustment, the psychiatrist starts with the bias of selection. The requirements of providing reasonable medical care necessitate that he study patients who have been referred. At first glance, it might be considered that the number of types of patients referred from the various facilities of the Home (apartment, room, dormitory, infirmary) would yield data as to which type of provision for the aged promises the best adjustment. We have not yet broken down our referrals in this way; when it is done, the findings will undoubtedly be of interest. However, there is no doubt that one item gleaned from such study will be that certain areas of the Home and particular members of the staff are more tolerant of some forms of disturbed behavior than others, and that to some "normal" behavior is distressing. Differences can be clearly noted even in so seemingly uniform

an area as the infirmary in which different shifts of nurses—possibly because of number of staff to perform the duties, medical and psychiatric alertness, or personal feelings and motivations—may make widely divergent estimates of a resident; one may refer him as a problem while the other deprecates the need for psychiatric assistance. Obviously then, "adjustment" of the resident is for the psychiatrist not only a matter of how the person adapts to his Home environment, but also of how the staff members of the Home and the institution as a social organization respond to and interact with the resident. Therefore, whatever his original intent, the psychiatrist soon finds himself evaluating and studying the referral source and its changing attitudes.

There was a time in the Home when, from a superficial point of view, it seemed that residents were either considered to be well-adjusted or mentally severely ill and in need of urgent, definitive, psychiatric care. Viewed even superficially, at present this is no longer a possible conclusion. Five years of experience has encouraged expansion of the medical program to provide more comprehensive psychiatric care than previously could be provided by consultants whose duties were for the most part diagnostic and advisory, chiefly with respect to "disposition" of the resident patients. The expanded program began with the appointment of a neuropsychiatrist who devoted several hours a week in the Home. He examined referred resident-patients and evaluated the mental and emotional state of applicants for admission whose capacity to adjust in the Home seemed questionable.

As an example, we may take the case of an elderly depressed widow who feels neglected by her children. Irrational but not unusual feelings are present that her husband's death was an abandonment; for this, she is angry. She is also angry, perhaps with some justification, for the seeming rejecting attitudes of her children. She is "looking for a home." Can the Home be the *home*? Is the Home willing to increase its facilities, reorient itself emotionally and psychologically in terms of staff attitudes to make the Home *home* by improving itself, or should the applicant be referred to a sanitarium, a psychotherapist, or some other agency? Efforts at solving such problems naturally came to include individual and group conferences with the medical staff, administrative officers,

nursing and ancillary staff, the social service department, and even the Board of Trustees of the Home. The discussions and conferences were in actuality a program, although not entirely planned, of psychiatric education and orientation. As these developments took place, the psychotherapeutic efficacy of repeated brief interviews with the aged patients became apparent, and the sustaining therapeutic benefits accruing from changes in staff attitudes became obvious. Individual psychiatric aid to the adjustment of residents in a Home could not be made available to large numbers or maintained and followed by a single psychiatrist; the neuropsychiatric staff was therefore increased so that at least ten to fifteen hours a week of psychiatric time was available, and a psychiatric social worker was added to the staff. By this time it was obvious that even such growth far from saturated the Home with psychiatric care. The needs far exceeded and still greatly exceed the psychiatric time available. This would imply that there is room for great improvement in the patterns of adjustment of aged persons in a Home and that recognition of social friction and of personal unhappiness tends to increase with increasing psychiatric alertness.

From one point of view, the psychiatric team was an investigative group: the presence of psychiatrists and a psychiatrically-oriented view of the Home comprised a survey of residents and resident-staff, community, community-Home relationships with interest in those problems arising, to the solution of which psychiatrists and psychologists may make significant contributions. From another point of view, the psychiatric team was a new factor in the dynamic functioning of the Home which introduced another variable into the natural experiment of individual and group adjustment in an institution. It provoked resistance, alertness, fears, resentments, expectations for magical solutions to problems, and other attitudes which altered the very persons and problems it came to examine or treat. Staff fears of exposure or criticism, of loss of prestige or power, and converse desires complicate the evaluation of resident adjustment and the influence of personnel on attitudes. The experiment with individual workers, popularized by Chase, in which attempts to determine how to improve working conditions through environmental change was invalidated, because the social change this

introduced grossly affected work (for the better), is a familiar example of the problem that confronts the psychiatrist who tries to examine adjustment patterns in the Home.

*General Patterns as Reflected in Therapy.*—For the psychiatrically-oriented investigator, it seems fair and reasonable to make the assumption that the relationship the patient tends to establish with a therapist is a crystallization of many aspects of that person's social functioning. The therapist who is sufficiently acquainted with his own impulses to action, their fulfillments, and with his effect upon others, can infer a great deal about the person's habits of reaction and means of adjustment from the latter's spontaneous actions and arrangements in the doctor-patient relationship.

Thus, the events that occur in therapy are to the therapist an indication of the patient's adjustment patterns within the Home community. He assumes that the adjustments the patients make to him are indices to the patterns displayed by them in their more usual everyday dealings with their confreres, their authority figures, and their servitors in the community. When the residents reach the psychiatrist their attitudes and associational flow of conversation indicate that the therapist is spontaneously delegated a surrogate parent. Furthermore, it appears that the residents, in their helplessness, have delegated staff members, and often other residents, to the same exalted status.

The general patterns discerned are a formulation of the observer and grow from the basic concepts he adopts as therapeutically useful. The basic concepts with which we operate are as follows: aging brings with it loss of resources—physical, economic, social, and psychological (the latter often including emotional reactions to aging)—which render the individual less capable of mastering environmental shifts and changes, of relieving tensions and gaining satisfactions, among which must be included pride in the achievement of bio-socially determined goals. The helplessness which comes with the changes called aging is added to helplessness determined by pre-existing psychological inhibitions, defects of development and inefficient habits or patterns of social behavior. In this setting, frustration is common, a subjective sense of helplessness inescapable. Anxiety and anger arise

and are psychologically elaborated in a manner predicated upon the individual's past, his actual and perceptual grasp of the present and his rational and irrational anticipations of the future. The anxiety and anger are to begin with essentially orienting and organizing but, more often than not, the emotional response is excessive and goes on to disorganize and disorient the person, increasing the helplessness and aggravating defects present. Consequently, the adjustments made by the individual may tend to be progressively less efficient adaptations which demand ever greater environmental manipulation by custodians if the individual is to survive. The custodial maneuvers can be decreased if overreactive fear and anger are meliorated and the organizing effects of fear and anger in the person are favored. When failures have lowered self-esteem or confidence, danger as signalled by fear disorganizes; it is therefore of paramount importance, whatever else is done, to favor a rise in self-esteem, worth, or self-regard. Such maneuvers are favored by psychological homeostatic patterns. For the purpose of illustration, the patients seen may be considered broadly as falling into two groups.

The first group may be categorized as the fearful dependents. They regard referral to the therapist as a threat. They feel it as the exertion of authority and as propulsion toward a powerful figure who has large-scale powers to harm, to dispossess, to expose and destroy as well as to help or heal. Their fearful approach to the therapist permits them to feel justifiably angry with him although he does nothing to reinforce their conviction of his malignant power. The mobilization of anger by the patient is accompanied by a sense of strength. This is pleasurable and is followed by a rise in self-esteem. Fearful dependency in this way yields to a state of mild resentful dependency. Permissive encouragement toward ventilation of the anger tends to decrease the anxiety, to dissipate the reasons for anger, and emotional over-reaction is ameliorated. At the same time, this contact, this familiarity with a person delegated as a surrogate parent gives rise to a state of pleasant expectancy, it arouses what invariably lies dormant in the human breast: hope. The hope is that the therapist is an omnipotent protector and leads to the illusion that this is exactly the case. Under such protection the

patient feels safe. That he has such a protector is evidence that he is worthwhile added to the rise in self-esteem which accompanied angry feeling. Because there is resentment to the protector which cannot be expressed, there is residual fear and guilt. Resentful displays to others similarly delegated as parental figures take place outside the patient-doctor relationship. Many of these encounters, especially if they are with staff members properly oriented to recognize them for what they are, may result in increased sense of strength and worth. The increased sense of worth leads to improvement in social relationships and the replacement of paralyzing and disorganizing fear with organizing anger has led to improved functioning. The anger in turn tends to dissipate itself as failures are replaced by successes. The process depends upon persistence of the belief that the protective figure is continuously available. A mild sense of guilt provoked by the resentful feelings tends to perpetuate this illusion.

A second group is that of the resentful dependents. They too feel referral to the authoritarian figure as a threat. This increases their anger and produces a sense of pleasure and sense of strength, which if verbalized would seem to say, "I am so enraged, he must be afraid of me. His fear proves I'm strong and capable." The attitudes, or often the simple existence of the therapist as a fore-judged inimical parental figure, connote punishment. If the therapist helps the patient to feel that the interview is the worst that will happen to him, then the pleas, injunctions, or exhortations of the therapist are viewed with a kind of tolerant contempt. "They didn't hurt me a bit—that supposedly important person didn't take me down a peg" or "I sure fooled him and got out of that. . . ." or "Didn't he back-track now when I let him have it" would seem to be some frequent trains of thought in such people after their first encounters with the psychiatrist. Moreover, because this has been a punitive affair, as viewed by the patient, he feels he has been disciplined, has tasted the rod and has earned forgiveness. There is no further need for great guilt about his angry thoughts and feelings. As in the fearful dependents, the session has resulted in a rise in self-esteem and in restoration of feelings of social approval which leads to better social functioning. The focalization of resentment on the therapist may at times be sufficient to decrease resentful

displays toward other parentified persons who are now considered of importance: thus, socialization is improved; increased success in social relationships, as with the fearful dependents, adds to personal dignity and emotional calm.

In this group, as in the former, emotional over-reaction has accentuated the effects of previously existing psychological inhibitions and has aggravated the disabilities related to any cerebral damage present. With a shift from disorganizing emotional over-reaction to the organizing functions of emergency emotion, relatively effective action becomes possible and situations that lead to emotional storms occur less frequently.

In both groups, as here defined, the relationship with the therapist has led to an illusion in the patient that he is able to master his social environment. This conviction depends on the continued presence of the therapist or the belief that the therapist, through delegation of his power, "goes" with the patient. The patient is supported by a belief that the therapist likes, respects, and protects him. Whenever this leads to improvement in actual social performance, it is a relatively healthy state of self-sufficiency that has been achieved, but one which rests on a precarious base—the continued illusions about the therapist.

It seems to me that these observations of events in the patient-doctor transaction can be generalized to the social functioning of the person in the Home and may be viewed as patterns of adjustment within a setting in which dependency feelings are either spontaneous or are aroused because of subjection to regulation, disposition and regime.

It must be emphasized that there are dangers in evaluating patterns of adjustment from a superficial point of view. The feelings of helplessness and vulnerability of the aged person who has failed to master environmental demands and changes, and who has been unable to achieve goals and satisfy tensions, lead to and are increased by a loss of self-esteem. The social environment is viewed as harsh, hostile, and damaging. It may be appeased, placated, dealt with by way of compliance, ingratiation, and submission. This may be mistaken for good adjustment. There may be avoidance, wariness, and self-protection. This too may be mistaken for good adjustment. The blaming of the environment may be the basis for frightened or angry demanding and querulous behavior. This is occa-

sionally mistaken for normal self-assertion. On the other hand, self-assertion may be mistaken for anger by staff members addicted to routine and orderliness.

Belligerence, truculence, paranoid attitudes quite naturally have their place in a personally contained schema wherein the world is hostile. Apathy and depression are common where anger arises and cannot be externalized. These reactions are quite common and may be dismissed as "normal" reactions. The alert interviewer is not long in the dark about these feelings from what the patient says and how he behaves with his doctor, who can evaluate their essentially supportive or disruptive potentialities in terms of the total context. Of great interest is the difficulty in differentiating primary from secondary gain in these elderly institutionalized persons. When the frustration appears to have been sexual in nature, for example, and a symptom has served to decrease anxiety, that frustration appears to have been one in which dependency needs have been sexualized. Thus, ultimately, the so-called secondary gain has been primary, and the original basis for the anxiety was a feeling of helplessness which led to desire for a protective parental figure. This topic is one which deserves further careful study.

From a prognostic point of view, it may be said that emotionally ill residents who demonstrate patterns of fearful dependency in which there are present ingratiation, relative immobility, submissive, and retiring characteristics are likely to make a good adjustment in the Home. However, applicants of an angry-dependent type—demanding, complaining, resentful—even though less disturbed than the former, are less likely to make what is called a "good" adjustment. The more healthily self-reliant appear to run the same risk as the angry dependent persons on admission to the Home. Just as anger of the neurotic may be mistaken for self-assertion, the self-assertion of the relatively independent aged person may be viewed by the environment as anger and may lead to staff-resident friction. It seems to me that this is a topic which needs considerably more study. It raises interesting questions about how we may differentiate persons who can or will tolerate well an enforced dependency status from those who are unable to do so, and about the relationship of coöperative and sensible attitudes toward mutual aid and freedom from

rigid conventionalization of response, as well as about our own valuation of, and investment in, formalized humanitarian efforts.

*Concluding Remarks.*—Adaptational maneuvers which are seen by the social environment as bad or by the patient as painful (and therefore called maladjustments) sometimes lead to a patient-doctor relationship. The reciprocating social arrangements and re-arrangements that comprise the resident-institution transaction within a Home is often crystallized in the relationship established by psychiatrist and patient when they meet to develop the controlled life-experience called psychotherapy. The control of this life-experience rests upon the therapist's understanding of his own needs and his recognition that he acts upon the patient from these needs while the patient has a special perceptual distortion of him as a healer and helper.

Many aged persons are relatively incapacitated for conventionally acceptable adaptation to their social environment because they have lost or failed to acquire the necessary resources. They lack social, economic, physical, or psychological means to relieve tensions, achieve goals, solve problems, and master discomfiting shifts and changes. Their adaptive maneuvers or adjustments in this state of reduced efficiency give rise to social frictions and personal pain. The adjustments made by an aged person who is psychologically, physically, or materially disabled are transactions which involve the social environment fully as much as the person. The individual's maneuvers stem from his needs and are the inevitable result of his past, his present circumstances and his view of the future. He acts and has acted upon a social environment which responds to him in a manner determined by its own conglomeration of proclivities to maintain itself as a society and also determined by the needs of the individual members of that society to make their own arrangements. In the care of these frightened and angry institutionalized aged our need for a sense of mastery of problems and for self-esteem may probably best be satisfied by recognizing how they elevate and maintain their own.

# AN APPROACH TO THE TREATMENT OF MASSIVE MENTAL HOSPITAL POPULATIONS

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WITH a renewed interest in the treatment of psychiatric disorders, mental hospitals are again turning to techniques for treating large patient populations. Idealism tends to be replaced by realities when planners of treatment programs are faced with shortages of personnel, finances, and other essentials for ideal treatment. This is particularly true in large state and federal hospitals where chronic populations increase in numbers daily. One technique for treatment of massive populations is the activity program.

Activity programs, like many other psychiatric treatment methods, have led a circular life of emphasis over the years. Modifications were made from time to time in methods, but essentially the goal remained the same—to break up patterns of psychotic behavior with a retraining in living.

Various names were applied to this process. Related are such titles as "Total Push," "Milieu Therapy," "Ergo Therapy," "Activity Therapy," "Educational Therapy," "Work Therapy" and "Activational Therapy."[1, 2, 3] This paper will describe the pilot study which led to our present "Activational Program" at Milledgeville State Hospital, Milledgeville, Georgia.

* The author would like to express his appreciation to Dr. T. G. Peacock, Superintendent; Dr. J. D. Combs, Director, White Female Service; and to the many others who contributed their support to this project.

[1] See "Results of Non-Specific Treatment in Dementia Praecox" by Clarence O. Cheny and Patrick Drewry, Jr., *American Journal of Psychiatry*, Vol. 95, No. 1, July, 1938.

[2] See "The Practice Of The Total Push Method In Treatment of Chronic Schizophrenia," by Kenneth J. Tillotson, M.D., in *American Journal of Psychiatry*, Vol. 95, No. 5, March, 1939.

[3] See "Theory And Principles Of The 'Total Push' Method In The Treatment of Chronic Schizophrenia," by Abraham Myerson, M.D., *American Journal of Psychiatry*, Vol. 95, No. 5, March, 1939.

*The Problem.*—Milledgeville State Hospital has over 11,000 patients in residence, with at present only a limited staff available to provide them with active care. There is a recognized need for some approach which will give the maximum benefit to these patients by using this limited staff efficiently. This experiment was undertaken in an effort to find means by which patient morale and general adjustment level could be raised and in the hope that some borderline cases might reach a sufficient level of adjustment for furlough.

*Wards.*—Freeman 7 was selected for the initial program, with Freeman 3 as a control. These wards contained one of the poorest prognostic patient groups in the hospital. When the program was initiated on January 1, 1953, each ward had a total of 104 patients. At present, the census totals 107 patients. According to the survey made by the American Psychiatric Association, each ward is 42 patients (65 per cent) over capacity. Freeman 3 was used as a control ward because it offered similar problems, being almost identical in terms of ward arrangement, number and type of patients, and number and type of personnel.

The philosophy of the wards presented additional problems to those already mentioned. The patients were generally known as poor prognostic cases, which gave the attendants little motivation to offer more than the necessary custodial care.

*The Approach.*—The decision to enter Freeman 7 was made following a discussion between the Chief of the Women's Service and the psychologist, and after consulting with the physician in charge of the ward. To enter this ward, the psychologist needed authority to function. At the same time, it was realized that an authoritarian approach to the problem would be fruitless since the very nature of the undertaking was to stimulate independent thought and action by the ward personnel, rather than to set up a structure which would operate only in the presence of the psychologist. It was decided to use normal channels of communication, with responsibility for patient care left to the ward physician and with considerable flexibility for therapeutic suggestions by the psychologist. Unforeseeable problems were expected and

it was agreed that further discussions from time to time would be more helpful than inflexible rules.

In actual practice, the psychologist advised the attendants, when asked, concerning minor management problems relating to the patients' psychological care. Major questions, such as furlough and type of treatment, were discussed and decided by the coöperation of ward physician and psychologist.

Rapport-building became the first consideration. A meeting was arranged between the ward physician, the Supervisor of Nurses for the Freeman Building and the psychologist for the purpose of discussing the aims of the program. Informality was followed throughout, in an effort to diminish resistance. Following this meeting, the supervisor introduced the psychologist to the head attendant on Freeman 7, who in turn presented her attendant staff.

In this first meeting with the attendants, it was apparent that they were to be a highly coöperative group but that this coöperation was to be of a routine authoritarian nature and not real acceptance. As expected, the personnel were suspicious of this new situation. By avoiding any form of direct criticism of the ward and by attempting to understand the problems from the attendants' point of view, the psychologist was able to alleviate many of the immediate apprehensions.

The general status of the ward revealed no bed-patients. Six patients were secluded from time to time, diminishing their destructiveness or general disturbance to the ward, and one patient was in seclusion most of the time. About sixty trays were served, in addition to the forty-two patients eating in the dining room. The dayroom seated approximately sixty patients during the day, most of whom were soilers. An average of eight electric shock treatments were administered each day.

The patient in seclusion was the greatest individual problem on the ward. She was destructive and ate her clothing, bedding, hair, and paper plates. She created a further problem by standing constantly which resulted in an edematose condition of her legs. Her problem was discussed with the physician with a view toward possible electric shock treatments. She had never received E.S.T. and at one time showed a rather good level of ward adjustment. The psychologist felt that if

contact could be accomplished with electric shock, other efforts might improve her general adjustment level. Other patient problems were reviewed in a similar manner.

There were about six to seven patients who went to the auditorium from time to time for various activities. Approximately twenty patients attended movies on another ward in the Freeman Building and these same twenty went for occasional walks. Only about eight patients did occupational therapy work, four going to the O.T. Shop while the other four worked on the ward. The majority of the patients were idle. Patients were roughly divided into "upper-hall" and "lower-hall," the upper-hall patients being of a higher adjustment level.

The psychologist found the dayrooms rather bleak and uncomfortable. A few magazines were furnished the patients and a small number of jigsaw puzzles were available, but these were not gauged to the level of the patients or else were incomplete. With these exceptions, no activity, other than routine care, reached the majority of the patients. For the most part these lower-hall patients merely sat around the room on benches.

From a standpoint of physical care, the ward was well managed. The patients appeared clean and well cared for. The attendants made an effort to train each patient to take a daily bath and this appeared to have raised the level of the patients' care.

The examiner checked the patients on the ward as to classification and found that the following statistics were existent as of January 5, 1953:

| | |
|---|---|
| A. Dementia Praecox or Schizophrenia | |
| Unclassified | 49 |
| Paranoids | 6 |
| Catatonics | 7 |
| Hebephrenics | 7 |
| With mental deficiency | 3 |
| TOTAL: *Dementia Praecox or Schizophrenia* | 72 |
| B. Phychosis with mental deficiency | 17 |
| C. Psychosis with psychopathic personality | 2 |
| D. Psychosis with cerebral arteriosclerosis | 4 |
| E. Psychosis with central nervous system changes | 1 |
| F. Psychosis with paranoid condition | 1 |
| G. Manic depressive, psychosis depressed | 1 |

| | |
|---|---|
| H. Psychosis with epilepsy | 1 |
| I. Senile psychosis | 3 |
| J. Psychosis, conversion hysteria | 1 |
| Total: *B. through J* | 31 |
| TOTAL ON WARD | 103 |

Classified by age, the patients grouped as follows (January 5, 1953 to July 1, 1953):

| | |
|---|---|
| Under 50 years | 66 |
| 50 through 59 | 27 |
| 60 through 69 | 20 |
| 70 through 79 | 10 |
| 80 and above | 2 |
| TOTAL | 125 |

(including furloughs, admissions and transfers.)

Patients were interviewed in alphabetical order. Each interview was directed toward evaluating the present status of the patient and determining her therapeutic possibilities. Three groups were used for therapeutic classification. Group I consisted of those patients functioning at a level sufficiently high to be in formal group psychotherapy. This required that each be in reasonable contact and have the ability to express herself adequately. Group II consisted of patients functioning at a level of reading or informal activation therapy and who might improve sufficiently for formal group therapy. Group III included senile, mental deficient, and extremely regressed patients who might benefit from habit training. Some patients were placed in either Group II or III, implying that a trial period would be necessary to find the extent of their therapeutic possibilities. Mental deficiency and organic problems were found to be more prevalent than indicated by classification.

The completed survey was as follows:

| | |
|---|---|
| Group I | 9 |
| Group II | 25 |
| Group III | 58 |
| Group II or III | 15 |
| TOTAL | 107 |

Early in the program, music therapy was introduced in the form of one-hour recordings. Selections were of both deep and light quality, in an effort to vary feeling tone. Patients

were asked for suggestions as to their favorite songs and it soon became apparent that billbilly music, marches, and religious numbers were most popular. Music was presented in sequence beginning with rhythm and then followed by melody, mood, and pictorial-associative music. This sequence resulted from research in music therapy at Eloise State Hospital in Eloise, Michigan.[1]

An immediate response to music was noted among many regressed schizophrenics. Some clapped with the rhythm of the music while others were motivated to dance. These music hours were continued at specific times each week.

By the end of the first week on the ward, one patient stated that she was being accused by others of taking up too much of the psychologist's time and that she wanted him to see all of the other patients so they would not think "something was going on" between herself and the psychologist. It was quite evident that transferences had already begun and the ward was incorporating the psychologist as therapist.

Since the ward presented such a large group of patients who were inactive, an appeal was made to both the Recreation and the Occupational Therapy Departments for additional aid. The Recreation Department responded by introducing regular game hours. Very simple games such as "Button, button, who has the button" and simplified handball games were used in the lower hall, while upper-hall patients played "Bingo" and the like. This department also began motion pictures for the more regressed which brought a surprisingly favorable response.

The O.T. Department responded in a like manner with additional attention. An O.T. worker distributed beads to be strung in the lower hall, offered cigarettes and engaged the patients in a number of other activities such as sewing quilt squares and individual sewing projects.

After two weeks, the psychologist discussed with upper-dayroom patients ideas for improving the comfortableness of the ward. The patients responded favorably and a group was organized to carry out some of these suggestions. Drapery material was obtained for the windows through the coöpera-

[1] See "The Past, Present and Future of Musical Therapy," by Ira M. Altshuler, M.D., *Educational Music Magazine*, Jan.–Feb., 1945.

tion of the Nursing Department and the pătients sewed and hung these. Scrap pieces of this drapery material were made into seventeen very attractive cushions.

The psychologist followed the assumption that attendant coöperation could best be obtained by attempts to demonstrate in a non-threatening fashion practical methods rather than introducing incomprehensible theories. By February, attendants began to show interest in the program and much of their original inertia subsided. The attendants suggested and supervised the sewing projects and became valuable aides to all the other visiting personnel.

*Therapy Approaches.*—Since this was an effort to reach a large number of patients, little individual therapy was attempted. A modified individual-therapy method by Karpman,[1] which is primarily biographical, was used in a limited number of cases. Individual projects of an activational nature were attempted with many patients and included activities such as art, piano, reading, and other activities of particular interest to individual patients.

The greater emphasis was on group psychotherapy and several types of approach were used. Two groups, consisting of eight patients each, met weekly for formal group psychotherapy and discussed problems of mental health. This approach showed promising results.

Another group consisted of five regressed portico patients who were still alert to their surroundings. They were engaged in reading simple stories, passing these from first one patient to the next. Response was slow at first but gradually all but one patient in this group read and improved her reading.

Informal group gatherings resulted from the music hour at which time discussions would often arise giving added opportunities for informal psychotherapy. The psychologist attempted to keep fresh newspapers and magazines on the ward and found that patients showed an increased interest, using these freely.

The University of Georgia sent several graduate students to the hospital during the spring to obtain firsthand experience with psychiatric patients. On four different occasions, these students were used as game activators. A surprisingly

[1] See "Objective Psychotherapy: Principles, Methods, and Results," by Ben Karpman, M.D., *Journal of Clinical Psychology*, Mono-Suppl. No. 6, July, 1948.

good response was seen and, following these periods, an increase in the number of spontaneous efforts made by the patients was observed.

*Ward Improvement.*—The attendants frequently raised practical problems related to ward and patient management. Whenever possible, an attempt was made to meet these needs or to refer the problem to the proper authority. Suggestions concerning how difficult patient situations might be handled were given to the attendants when requested. Several patients who presented difficult problems were improved by a fresh approach on the part of the attendants.

The number and quality of games were improved and the attendants were encouraged to participate in stimulating patient activity. A piano was secured for the benefit of those individuals who could play, as well as to increase group singing and social participation.

Our activational program was a total unit program which attempted activation of the ward as a whole. Action groups were formed only for specific projects. Each group had an attendant advisor and groups were changed each month by patient elections and appointments.

Motivation for ward O.T. activities was accomplished by using profits for the purchase of articles beneficial to all patients on the ward. In this manner many comforts were added that otherwise would not have been obtainable through regular budgetary channels.

Activation techniques were designed to create dependent interaction of patients. Examples of this are choral groups, patient government meetings, and birthday parties with patient-sponsored programs. Patient government was particularly successful in that many action or working groups were formed which necessitated coöperation. Coöperation must exist to nominate officers, conduct elections, conduct ward-improvement projects, present patient entertainment, and present choral concerts. Some patients took partial responsibility for other patients, which resulted in broadened outdoor activities.

Activities such as card games, conventional checkers, Chinese checkers, ping-pong, volley ball, baseball, sack races, quilting, shuffle board, dancing, spontaneous singing, ball-tossing, horse shoes, news-reporting use of bulletin boards for

communication, and some forms of manual arts created interaction of a high level.

Not all activities fulfilled this level of interaction. However, T.V., magazines, books, newspapers and motion pictures often gave rise to spontaneous interaction.

*Results at End of Six Months.*—During the six-month period, eight patients were furloughed—four as improved, three slightly improved, and one with no change. In addition to the furloughs, three patients showed definite improvement and one slight improvement. One hundred and three patients showed little change other than an increased alertness to their surroundings and a general improvement in patient morale. During this same period, only one patient was furloughed from the control ward and little change was noted in the total ward activity.

The patient mentioned earlier, who had been in seclusion for two years, was sufficiently improved to remain in the day-room. Her hair, which she had extracted, had grown back and her physical condition had improved. She had gained weight.

Several suspected cases of epilepsy were referred for electro-encephalographic studies, and two of these were later placed on medication by the physician.

There was some decrease in soiling in the lower-hall day-room.

Activities which required personnel participation were most effective in breaking through the psychotic world of the patient.

At the end of six months, the attendants, occupational therapy workers, recreation departmental workers, nurses and the ward physician were all agreed that the general level of the ward had improved and that some patients had greatly benefited from the program. The coöperation of the various departments in approaching this task clearly demonstrates the advantages of collective service and points up a need for an increase in "team approach" to the continued-treatment wards.

The psychologist concluded that the Freeman 7 project was successful in demonstrating an approach to the problems on continued treatment wards.

# THE UNMARRIED MOTHER OF SCHOOL AGE AS SEEN BY A PSYCHIATRIST *

FLORENCE CLOTHIER, M.D.

THE problem of illegitimate pregnancy captures the imagination. It always has and I suspect that it always will—human drives and cultural inhibitions being what they are. Ancient ballads (and some not so ancient), novels and plays of every generation, and kitchen, parlor, and locker-room gossip all attest man's interest in this very common biological phenomenon.

The universal popular interest evoked by the girl or woman who has become pregnant outside of marriage has an excited, furtive quality that marks it as charged with strongly ambivalent affect. We humans do find vicarious gratification for our own forbidden impulses in the phantasies aroused by the individual who has not only transgressed the social code but "been caught" and thus merited punishment. Illicit sexual relations, pregnancy, and childbirth touch off in all of us repressed and guilty wishes, frustrations, and anxieties. It is these feelings which condition society's attitude towards the unmarried mother and her child.

In cultural groups where rigid patterns of morality prevail, repressed impulses for sexual gratification run in a strong current. Individuals, to protect the social structure against their own submerged desires for forbidden sexual gratification, direct aggression and punishment against the unmarried mother and her child who have mobilized their own hidden wishes and hence their defenses against those wishes. The "fallen woman" and the "bastard" are viewed by society not as individuals but as projections of strong desires and even stronger defenses against those desires. Because women even more readily than men are threatened by identification with the unmarried mother, they are usually the more vociferous in their condemnation and more cruel in their punishment. Though churchmen, educators, social workers, and parents

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may consciously deplore it, mankind likes its wrong-doers whose acts give them indirect satisfactions while at the same time providing an opportunity for righteous indignation and even at times relief of tension through aggressive expression. The unmarried mother, herself a part of the cultural background, readily allies a part of herself with the punishing public and often welcomes ways of expiating her guilt, which lies deeper than her offense against the cultural mores.

Churchmen, educators, social workers, physicians, and the do-gooders are also human beings with forbidden impulses and strong culturally determined defenses against those impulses. Our professional literature, institutes, and activities in behalf of unmarried mothers and their children bespeak our nicely sublimated preoccupation with the same dynamic struggle that concerns the rest of mankind. Our professional orientation allows us not only unusual (but still indirect) gratifications of primitive impulses, but also provides us with the direct tension-relieving activity of doing something for society and for society's scapegoats—the unmarried mother and her child. It is well to remember that though consciously we find satisfaction in doing something for the unmarried mother, she unconsciously is doing something for us!

The old attitude still prevalent outside of professional circles that the unmarried mother is a bad and fallen woman is our society's most direct defense of its culture which is built around family life. The pseudo-psychologically oriented attitude that "to understand all is to condone all," indicates an identification with the unmarried mother's forbidden indulgence, or neurotic acting out of phantasies, rather than an identification with society's need to preserve for itself and the mother and her children the pattern of family life. It has been said that psychiatrists, particularly psychoanalysts, were to blame for social workers having turned away from an interest in serving society to an interest in serving individuals who are disturbed and whose activities disturb society. Social workers in becoming case workers are by definition focusing their attention on the needs of the individual client. But the unmarried mother and society can be well served only if the case worker can identify both with her needs and with society's needs.

Psychological understanding of the individual client must

be used to help the client so that her impulsive or neurotic behavior will not further jeopardize her own future or that of the child. Her needs must be so fully met that she will not again be impelled to violate the social order. Too often psychological understanding is exploited by psychiatrists and case workers for their own glorification. Instead of using our energies and knowledge to protect immature or neurotic girls from a form of symptomatic behavior with particularly far reaching social implications, we talk and write papers and present cases. We have made some progress in protecting the unmarried mother and her baby from having to bear the full brunt of man's projected defense against his own guilty impulses. But our own emotional involvement still limits our best efforts particularly in the direction of prevention. Psychological sophistication can serve as a smoke screen covering envy of the girl who has captured a man—even a phantom man—and who has achieved motherhood. This envy is not to be tolerated consciously and is reacted to with furious but satisfying activity in behalf of the unmarried mother, her child or prospective adoptive parents.

Even now with all our vaunted psychological understanding and individualization of every case, we fall into the trap of classifying all immature, neurotic, and psychologically healthy girls, who happen to have become pregnant outside of marriage, in the category of unmarried mothers. Such classification has social meaning but no more diagnostic value than to classify all patients who throw up as vomiters. Unmarried motherhood is a symptom of cultural-psychological disharmony. It is only one of countless possible manifestations of an individual's immaturity or of her conflict with her environment or within herself. Only an encyclopedic study of both sociology and psychology could hope to cover adequately the possible dynamic or etiological factors involved in producing the symptom—unmarried motherhood.

Our own personal and professional experience confirmed by a survey of the literature teaches us that the unmarried mother does not exist as a stereotype. She is many women. She may be feebleminded or highly intelligent. She may be at the end or at the beginning of her child-bearing period. She may come from a background of apparent security and wealth or she may have had no home she could call her own. She

may be struggling to solve a neurotic conflict or she may be a pawn moving under the dictates of psychotic phantasy or delusion. She may, like the psychopath, be acting out primitive impulses without regard to society or future implications for herself and her baby, or she may be psychologically mature and healthy caught in a reality cultural dilemma. If we wish to generalize, all we can say is that the unmarried mother is the girl or woman who because of her own constellation of environmental and psychological factors has violated the social mores of our culture and has accidentally or with deep intention become pregnant. In the eyes of society having become pregnant, regardless of why she became pregnant, places the woman in the culturally dangerous but psychologically useful category of unmarried mother. Once pregnancy has called our attention to an unmarried girl or woman, it is time to try to understand the dynamic factors which in her particular case produced this particular symptom. Only when we have an understanding of the personality make-up of the individual unmarried mother and of the cultural factors in her background can we hope to help her to plan wisely for her own future and for the future of her baby. Regardless of our own emotional involvement with the problem in general or with the individual client in particular, we must hold to the goal of serving society by wisely serving its children and its offenders. Wise therapy requires consideration of all determinants.

Of all groups of unmarried mothers, the teen-ager represents the most challenging problem. She is still a child herself whose problems cannot be separated from her parents and whose treatment must include consideration of the family on whom she is still dependent. Her personality is not yet fully crystalized and society still has a chance to win her into satisfying acceptance of its mores. The schoolgirl unmarried mother is an adolescent and psychological factors peculiar to adolescence always play a rôle in her having become pregnant—just as these same factors frequently play a rôle in the older but still immature unmarried mother. Before discussing a possible particular symptom of disturbed adolescence—illegitimate pregnancy—it is well to review briefly that turbulent period between childhood and adulthood which is part of everyone's experience in the process of growing up.

Adolescence is a critical period because of two strong confluent currents—one biological and the other psychological. The system is bathed with sex hormones producing rapid reproductive maturity and impelling sexual demands in an individual who in our culture is still far from emotionally or socially mature. The more highly developed and complex the cultural pattern, the wider is the gap between lusty biological maturity and social maturity. It is this gap which is so often filled with discordant sexualized activity. But this gap can be utilized to prepare youth for life in our increasingly complicated world, if energies biologically released can be diverted into the sublimated channels of education.

As the girl begins to undergo profound biological changes affecting her feelings as well as her physique, she becomes frightened and insecure, and she clutches at the dependency which in her infantile development stood her in such good stead. She wants and tries to remain a child secure in her dependence on mother and father. But she is no longer a child. Her relationship to mother and father has been complicated by the Œdipal development. She has formed new identifications outside of the family and she is pulled along in the tide of her peers' increasing struggle for independence. The drive for emancipation from family becomes as impelling as the sexual drive, and often the two drives serve each other's ends. Neither the biological nor the psychological drive can achieve realistic, mature, and satisfying expression without overcoming the conflict barriers implicit in the girl's earlier childhood relationships. Certainly it is doubtful that an individual can attain satisfying independence if she has not savored fully the gratifications of infantile dependence. Where dependent needs have not been met, the drive for independence is tentative or is so colored by anger and frustration that it can lead only to distorted or aggressive activity against an unloving and therefore unloved world.

Adolescence is a period of strain in which the girl must integrate her conflicting sexual and emotional drives with the conflicting demands of her widening social horizons. If childhood emotional development was beset with difficulties so that the little girl felt herself rejected and unloved, we can expect a disturbed adolescence. The old anxiety "mother does not love me" reappears as the adolescent complaint

"nobody likes me." Feelings of loneliness, anxiety, hostility, and frustration can intensify sexual urges already strong. The girl who suffered in childhood from guilt because of sexual curiosity or play will inevitably suffer from more guilt and more anxiety when sexual interests become so strong that they can no longer be repressed. Ungratified dependent needs, affection, and acceptance are sought outside the home. The adolescent who has not experienced the giving and taking relationship of love with her parents, or who has had only casual interest on the part of substitute parents mistakes the attention of the casual interest of boys for love. If she has not had relationships, she cannot evaluate relationships.

The adolescent, in her drive for emancipation, needs to form new attachments outside the home and inevitably meets new authorities (often she takes her peers as authorities) and new standards of behavior. She strains to live up to the new patterns of behavior and to integrate them with the patterns and standards which until recently she had accepted as the only way of life. The greater the discrepancy between the standards of her home and the standards which she meets in the broader community, the greater the likelihood of her feeling unloved or that something is wrong and peculiar about her. "I'm not like other people." "Nobody feels like I do." "Nobody understands me." Driven by inner fears of inadequacy or by feelings of guilt, the adolescent tries frantically to make herself somehow acceptable and to build up her self-esteem through winning attention or approval not from her family but from her new attachments. The conflict element is particularly sharp where the adolescent has strong loyalties to her past and where she has the capacity for loving and admiring those who introduce the new ideas. This conflict of standards is the typical and normal psychological conflict of adolescence. The girl is challenged against a background of biologically sexualized emotionalism to reconcile authorities and to come into some satisfactory working relationship with her own conscience.

It is small wonder that the adolescent feels overwhelmed not just by the nature of her conflicts and feelings, but by their very intensity. Her capacity to feel, which she interprets as a capacity to love, has been heightened. When emotions and problems begin to get out of control the individual is

overtaken by anxiety which the adolescent girl experiences as uneasiness, apprehension, and moodiness and which her parents experience as petulant and irrational behavior. Her changeable, inconsiderate, and stormy behavior are her distorted defenses against anxiety as she tries to integrate new standards with old, to liberate herself from old dependencies and to form new attachments, and to so manage her sexual feelings that she can find satisfactions without being overwhelmed by guilt.

Perhaps the best defense against feelings of self-doubt and inadequacy is an air of self-assurance. Adolescents can be positively frightening in their "know-it-all—you're-an-old-fogey" manner. But that defense is brittle and behind it the adolescent longs for help—hence the popularity of the "Tips for Teens" type of newspaper column, magazine, and books. Today's anxious parents, unsure of their own standards and frightened of their seemingly competent teen-age daughters, shy away from inevitable rebuffs and fail to help their daughters to learn how to "get along" with boys, what to talk about, and how far to go. There has been a cultural change in the direction of permissiveness which has not necessarily made adolescence easier.

In general, adolescence is easier where the girl within her own family circle has experienced a normal Œdipal development with a strong identification with her mother and a strong attachment to her father. The formation of new, meaningful attachments can only occur where there have been past fully experienced relationships. The personality is adequate to cope with the stress and strain of adolescence if there is incorporated into the structure of personality the not-too-rigid authority of an adequate, loving parent. Where love has not existed and identifications have not been formed, or where love objects have themselves been inadequate, we cannot expect to find an adolescent with strong enough inner authority and assurance to meet the strains of growing up without symptom formation which is likely to jeopardize her relation to society. In cases where the girl's childhood has been spent in an institution or where she has been shifted from foster home to foster home, there has been no opportunity for the building up of enduring attachments. Secure and adequate identifications have not been formed and the adolescent with a weak and con-

fused super-ego is easily influenced by any and every new association which she may mistake for an authority or for a love object. It is this adolescent, who has never known love and who has no incorporated standards, who is constantly and without good judgment seeking attention, approval, and acceptance.

The most disturbed adolescents are those who have been deprived of their parents' love, particularly the mother's love because of death, separation, or rejection. A satisfying tie between mother and daughter helps to control sexual urges and to direct those urges towards marriage and a family. An underlying wish to conform to her mother's and society's conventions provides a stable basis on which to meet the strains of adolescence. But a satisfying tie must not be confused with an over-dependent relationship to the mother which will inevitably block emancipation efforts. The mother, whose guilt forces her to compensate for her rejection of her daughter by over-protection of her, sets the stage for adolescent anxieties and tensions. The daughter is likely to feel rejected, but because of all her mother does for her and because of her identification with her guilty mother, she always carries an extra burden of guilt which may become too much for her when forbidden sex impulses overwhelm her.

An intra-psychic conflict which every girl must solve in the course of growing up is the so-called masculinity-femininity conflict. The road to feminine maturity is not straightforward. There are many girls who do not easily accept the satisfactions implicit in femininity and who strive for masculine goals in a distorted effort to live out an underlying wish to be a boy. Other girls attempt to revenge themselves on their mothers or on mankind for having cast them into what they feel to be an inferior and humiliating rôle. The active tomboy girl in particular resents menstruation and the physical changes of puberty. Deep conflicts stem from the bisexual nature of man and woman. These conflicts should be solved in the course of the Œdipal development when the little girl finally accepts an identification with her mother in spite of her jealousy and hostility. Then, too, she takes her father and subsequently another masculine prototype as a love object. This psychological achievement can only be fully accomplished where the girl can accept passive rather

than active libidinal aims. Feminine narcissism and feminine masochism when properly integrated into the personality become sources of normal satisfaction, but like any other trait they can get out of balance so that society or the individual is damaged by them.

Psychic conflict is normally cushioned and made bearable by escapes into phantasy. Adolescence is a period when phantasies play a particularly important rôle. Life then is tolerable only because the girl or boy can for periods escape from both intra- and extra-psychic conflicts into a world where wishes stemming from the id, the ego, and the super-ego can prevail. Conscious phantasies, like neurotic symptoms, partake both of impulse gratification and guilt-relieving punishment for that gratification. Active and passive, aggressive and masochistic aims can be satisfied in phantasy, but denied reality expression because of the individual's respect for the social consequences of his behavior. Typical daydreams of the adolescent girl are phantasies of being raped, of acting as a prostitute, or of having a baby like the Virgin Mary without sex relations. In the rape phantasy, masochistic aims are deeply gratified. In the prostitute phantasy, the girl succeeds in playing the aggressive musculine rôle and perhaps further in symbolically castrating the man by taking his money or giving him a disease. In the parthogenetic (virgin birth) phantasy, the girl denies the need of sex or of a man and focuses her hopes on having a baby and being a mother.

The development of a sense of reality or a strong ego is one of the most important accomplishments of childhood. The girl who can accept the world as it is and not as she wishes it to be, and who has the flexibility to adapt herself to our cultural standards, while at the same time finding satisfactions, has achieved some degree of maturity and stability. It is this respect for reality implications and for our cultural standards that normally prevents an adolescent girl from acting out the phantasies which accidentally or purposefully might lead to her becoming pregnant. This same reality sense should protect her from impulsive gratification of her sexual needs heightened by the hormonal changes of puberty. A good reality sense and a strong ego should not be so overwhelmed by neurotic conflict that the girl acts out in a way that can only bring disaster on herself.

Unmarried motherhood in our culture almost always represents a distorted or unrealistic way out of inner difficulties. It is thus comparable to a neurotic symptom on the one hand or to impulsive delinquent behavior on the other. The adolescent girl who has sexual relations with men or boys is lacking in a capacity to protect herself. Her reality sense is not sufficient to cope with her biological drives or with her conflicts centering around her struggle for emancipation. Wishes, conflicts, or phantasies are acted out and by accident or design the girl may become pregnant.

Obviously the ego may be weak and the reality sense inadequate for a great variety of reasons. From what has been said about adolescence it does not seem surprising that unmarried motherhood should occur as a not uncommon symptom. United States Children's Bureau statistics indicate that approximately 46 per cent of illegitimate births are to mothers between 15 and 19 years of age. Adolescence is a period of crucial stress and it requires a strong ego to weather the biological and psychological storm with equanimity. Our adolescent unmarried mothers are usually bewildered, struggling girls who have never achieved an inner harmony. Constitutional factors and even more significant factors in the girl's own family life determine whether her reality sense will be strong enough to protect her from her impulses, and whether her ego will be free enough from neurotic conflict so that she will not hazard her future in a distorted effort to solve her conflicts.

Dr. Margaret Gerard has described the commonest type of unmarried mother as the "impulse ridden character." This is the childish, irresponsible, pleasure-seeking girl who with little thought as to future implications yields to temptation or to her wishes. To this girl reality consequences to herself, her baby, and her family are insignificant in comparison to her need to find the satisfactions which she feels she has missed. Because of her own emotionally neglected childhood, she has not established personality strengthening relationships and identifications. Her personality structure is flimsy and she is not capable of protecting herself or of making adequate plans for herself or her baby. In the childhood histories of these impulse-ridden girls, we find gross evidence of family disorganization. They come from broken homes or bitterly

unhappy homes, or from institutions, or from a series of foster-home placements. If there have been consistent objects for identification, it is likely that these have been with socially maladjusted individuals. As Dr. Viola Bernard has stated, we find a high incidence of mothers of socially disturbed adolescent girls, including those who become illegitimately pregnant, who provide as models for identification only confusion, inconsistency, and frightening unpredictability. The daughters of these mothers have been crippled by the lack of an essential need for healthy personality development. It is interesting how often a girl who was herself illegitimate produces at an early age an illegitimate baby, whether or not she has actually lived with her own mother. It is as if the mother's destiny forced itself on the daughter by actual identification, or by the daughter's groping for an illusory happiness.

The impulse-ridden girl may have been bred in such a hostile environment that she has no conception that love can exist between people or that in responsibility there can be satisfactions. Her relations to people are clamorous efforts to squeeze from them some satisfaction for her still-impelling need for gratifications of a dependent sort. She wants, at any cost, attention and approval and material evidences of acceptance. But because she cannot give herself into a relationship with another human, she cannot love. Her relations with both men and women are colored by the same mistrust and lack of warmth that poisoned her childhood. Yearning for something which her circumstances have made it impossible for her to achieve, this personality-crippled and vulnerable adolescent remains naively hopeful that through her sexual powers she will find a man who will compensate her for her deprivations and who will give her self-assurance. She submits gratefully to any man who is friendly and gives her a good time, or even to anyone who excites her—and because of her unhappiness and weak ego and super-ego development she is easily excited! The impulse-ridden character is emotionally immature and her primary motivation is to find someone to give her what she mistakes for love. During the love making and the sexual act, even though intercourse in itself is not satisfying and perhaps unpleasant, the adolescent has the short-lived and frustrating phantasy that she is needed, wanted, and loved. Her judgment and reality sense

are so poor that she cherishes the hope that each new man may bring her that for which she is searching.

The impulse-ridden character is likely to be promiscuous and if she becomes pregnant it is by accident. Because she is herself essentially unresponsive, her relationship to the father of her baby has no reality base. It is the derivative of a dream and the man has for her an ephemeral phantom character. He is what Ruth Brenner speaks of as a "ghost lover." Such a girl, who has not been loved as a child and who cannot relate to other girls or to boys and who is driven by strong though selfish sexual drives, has no true maternal feelings for her baby. If she is interested in it at all, it is only in the hope that through it she can gain satisfactions for herself. The capacity for full maternal love is granted only to the mature and satisfied woman who because she has received much can give generously and joyously. Physiological motherhood in our culture, even in the healthiest of girls, can occur years before maternal feelings assume the same strength as sexual feelings. The adolescent impulse-ridden character is incapable of the overwhelming and satisfying and sustained tenderness of maternity.

Married or unmarried, these immature girls make poor mothers. They transmit to their children through the emotional climate they provide for them the same primary emotional disturbances which crippled their own development. The indication would seem to be to make it easy for them to give up their babies in the hope that better provision can be made for the baby than was made for its child-mother. Society's traditional punishing attitude that keeping the baby will force responsibility on the mother and make her "settle down" is doomed to bring only tragedy to the baby and the young mother whose fundamental needs are still unmet.

It is interesting how often these girls, who are oriented only toward achieving their childhood goals, block out of consciousness the man, their pregnancy, and eventually the baby. For months they deny to themselves and to the world that they are pregnant. Dr. Viola Bernard describes one teen-age girl who even when in labor insisted that she was merely having an attack of appendicitis. When these emotionally immature girls finally do admit that they've "been caught," they do what they can to derive satisfaction from the situation for

themselves. Being cared for by a case worker can be utilized to satisfy dependent needs. If the girl's personality is not too rigid in its distortion, the case worker has a challenging opportunity to contribute of her own strength and integrity to the girl's super-ego, so that she will no longer be ridden by impulses and dissatisfactions. The case worker's rôle with such a girl is to establish herself firmly as a needed object of identification. It is her aim first to meet dependent needs and to strengthen the girl's reality sense, and then to help her towards a satisfying independence. Many of these impulse-ridden characters are inaccessible to help because of their total inability to relate and because of a complete absence of inner conflict in regard to their way of life.

The adolescent unmarried mother who goes to a maternity home can often find tremendous satisfactions in this group situation where she is cared for and where for once she is like everyone else. Boarding schools and group placements have definite positive values for many types of disturbed adolescents, and under wise leadership the months spent in the maternity home can have emotional and educational value, particularly if both group treatment and case work services are available. It is tragic that so many of our maternity homes regard themselves and are used as shelters for unmarried mothers with no effort at segregation of the women and girls on the basis of their psychological and cultural needs. The continued existence of such homes is good evidence of society's unwillingness to recognize that unmarried motherhood is a symptom of cultural-psychological disharmony rather than a diagnostic category.

The reality sense may be undeveloped because love relationships and adequate identifications have not occurred and the super-ego is unformed, or it may be distorted because of unresolved intra-psychic conflict. In the latter case, a guilt-ridden, punishing super-ego holding the whip-hand may direct the development of a neurotic symptom which may take the form of illicit sexual relations and/or unmarried motherhood. It has been my experience that in clinic work many more adolescent unmarried mothers fall into the impulse-ridden character group than into the psychoneurotic group. In private practice I have seen a larger proportion of the adolescent psychoneurotics. Of the older unmarried mothers, even

in clinic practice, one sees not only impulse-ridden characters but also a number of psychoneurotics. Among these older girls and women there is a noticeably larger group where the primary unconscious goal is to have a baby, rather than the baby's being an accidental complication.

When unmarried motherhood in the adolescent is on a psychoneurotic basis, one can be sure that, as in every neurotic symptom, there are elements of deep instinctual gratification and of punishment for that gratification. The underlying conflict may center around ambivalent feelings towards the mother so that the girl defies and punishes her mother while at the same time punishing herself. Or the conflicts may result from a variety of attitudes towards the father. Leontine Young has discussed the influence both of weak passive fathers and of too dominating fathers. On the one hand the girl is compelled to turn to men in order to dominate them as her mother dominated her father. On the other hand she chooses men who will hurt and humiliate her. Perhaps her guilty wish to revenge herself on her father has led her to submit masochistically to his prototype. In some cases, the father figure has been absent or lacking and the girl's phantasies about him and his relationship to her mother and to her have remained uncorrected by reality. Other girls caught in their Œdipus relationship have failed to make a transfer from father to other boys or men. Guilt feelings are strong because of the incest taboo and in this situation rivalry and identification with the mother and the longing to have a baby by the father makes the having of a baby under punishing circumstances a primary motive. Distorted feelings of guilt connected with the adolescent's drive to become emancipated from demanding rigid parents can play a significant rôle.

The psychoneurotic individual suffers from an impaired reality sense because intrapsychic conflicts are so impelling that psychic energy which should be available for perceiving and dealing with reality and for making plans on the basis of long-time values is absorbed by the inner conflicts. In promiscuous sexual relationships, or in an out-of-wedlock baby, the anxiety ridden girl tries to find an answer to her unconscious conflicts and needs. It is this girl who may act out her rape, or prostitute, or parthogenetic phantasies. Where neurotic mechanisms are so powerful as to produce symptoms destruc-

tive to the self and to others, psychotherapy or psychiatrically oriented case work, extending many months or years beyond the lying-in period, is advisable. Among older unmarried mothers in this category there may be a real question as to whether they should keep their babies. I have never seen a school age, neurotic, unmarried mother who I have thought would gain by keeping her baby, or who would be able to provide well for her baby.

The adolescent girl, unprotected by a firm reality sense, is predisposed to sexual relationships and illegitimate pregnancy by her biological sexual drives and by the conflicts stemming from her struggle to integrate new standards with old. Where infantile needs have remained unsatisfied, or where infantile conflicts are still unresolved, adolescence is disturbed and an illegitimate pregnancy may be a particularly virulent symptom of that disturbance. A predisposition to a disturbed adolescence fortunately does not mean that illicit sexual relationships or unmarried motherhood will occur. Pregnancy out-of-wedlock is always over-determined and both sexual and non-sexual motivations play important rôles. The adolescent girl, driven by sexual feelings, may attempt to meet long-standing non-sexual needs through promiscuous relationship with boys or men, or through motherhood.

The emergence of this tragic symptom may be precipitated by any one of a variety of causes which has served to mobilize old frustrations, anxieties and conflicts. Current reality situations may exist which strike at the adolescent girl's feeling of security and self-esteem. The adolescent's uncertainty and self-doubt renders her vulnerable to even trivial trauma. She is touchy and easily hurt by loss of love or by criticism so that her tenuous equilibrium is readily upset. Forbidden sex relations will still not occur unless conditions in the external environment are favorable for the symptom—though unfavorable for the girl and especially for her potential child. The influence of the social milieu cannot be disregarded. Where sexual relations are not uncommon among high-school-age boys or girls, the girl can more readily allow herself "to be laid." When there is available a sexual partner who urges necking and intercourse, and who may even provide a car or a hotel room, the girl, who is predisposed to impulsive or

neurotic acting out and who believes that the man may assuage her needs, succumbs to his attentions.

As an attempted solution for frustrated love and security needs, or as a way out of neurotic conflict, unmarried motherhood is doomed to hopeless failure. To the girl's original frustration and confusion are added stupendous responsibilities which she inevitably will have to evade. Her old feelings of rejection, "Nobody likes me," are given a firmer reality base. She has lost her "ghost lover" and society has branded her a bad woman. The symptom "unmarried motherhood" has numerous highly individual psychodynamic determinants. Particularly in the case of the adolescent girl it has also important psychodynamic consequences affecting not only the future adjustment of the baby but also of the mother—herself a child.

# TOWARDS A DEFINITION OF GROUP PSYCHOTHERAPY

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THE term *group psychotherapy* was first used by J. L. Moreno in 1931, in reference to a suggested plan of penal reclassification based on sociometric principles.[1] The meaning of this term has since been expanded to refer to the clinical treatment of individuals in artificial groups, as well as the treatment of already formed groups such as prisons. Moreno apparently resists this construction saying, "In individual therapy the patient is an individual. In group therapy the patient is a group."[2] But Bion and Rickman accept both definitions stating, "The term *group therapy* can have two meanings. It can refer to the treatment of a number of individuals assembled for special therapeutic sessions or it can refer to a planned endeavor to develop in a group the forces that lead to smoothly running coöperative activities."[3]

In the clinical sense, group psychotherapy refers to a variety of specific techniques, some of which appear to have little in common. Perhaps for this reason, there is a degree of confusion as to what group therapy is. As an example, Wender[4] does not believe that the Repressive-Inspirational method of Marsh,[5] the Will-Training method of Low[6] or the Text-Book Mediated method of Klapman[7] are really group psycho-

[1] See *Application of the Group Method to Classification* by J. L. Moreno. New York: National Committee on Prisons and Prison Labor, 1932.

[2] See "Group Psychotherapy: Theory and Practice," by J. L. Moreno. *Group Psychotherapy*, Vol. 3, 1951, pp. 142–188.

[3] See "Intra-group Tensions: Their Study as a Task of the Group," by W. R. Bion and J. Rickman. *Lancet*, Vol. 245, 1943, pp. 678–681.

[4] See "Reflections on Group Psychotherapy," by L. Wender. *Quarterly Review of Psychiatry and Neurology*, Vol. 6, 1951, pp. 246–248.

[5] See "Group Therapy and the Psychiatric Clinic," by L. C. Marsh in the *Journal of Nervous Diseases*, Vol. 82, 1935, pp. 381–393.

[6] See "The Combined System of Group Psychotherapy and Self-help as Practiced by Recovery, Incorporated," by A. A. Low. *Sociometry*, Vol. 8, 1945, pp. 332–333.

[7] See "Didactic Group Psychotherapy," by J. W. Klapman. *Diseases of the Nervous System*, Vol. 11, 1950, pp. 35–41.

therapy. Harms [1] states that much of what is called group psychotherapy is really collective therapy, although he does not define precisely either term.

It is our intention to attempt to construct a definition of group psychotherapy which may approach maximal satisfaction, through an investigation of some of the pertinent literature and by an analysis of actual behavior in this field of social action.

*Individual and Group Psychotherapy.*—Is group psychotherapy merely an expanded form of individual psychotherapy? Opinions differ on this point. Spotnitz [2] believes that individual therapy is really group therapy since the process is not only beneficial for the patient but also for the therapist. Ackerman,[3] in essential agreement, states, ". . . these two persons, the patient and the therapist are a group and provide a social experience." However, we shall not make an issue out of this point, and shall accept the general view that group psychotherapy requires a group of at least three persons.

But is the process of group psychotherapy essentially the same as that for individual therapy? On this point we find two sharply contrasting views. E. H. Erickson,[4] for example, doubts the existence of any really different psychological laws. Freud, writing about this point, states: "The contrast between individual therapy and social or group psychology, which at first might seem full of significance, loses a great deal of its sharpness when it is examined more closely . . . from the very first, individual psychology is at the same time social psychology as well."[5] Slavson states: "Group therapy is basically a special application of the principles of individual

[1] See "Group Therapy—Farce, Fashion or Sociologically Sound?" by E. Harms. *Nervous Child*, Vol. 4, 1945, pp. 186–195.

[2] See "Group Therapy as a Specialized Technique," by H. Spotnitz in *Specialized Techniques in Psychotherapy* by G. Bychowski and J. L. Despert. New York: Clarke, Irwin, 1952.

[3] See "Group Therapy from the Viewpoint of a Psychiatrist," by N. W. Ackerman. *American Journal of Orthopsychiatry*, Vol. 13, 1943, pp. 678–687.

[4] See "Ego Development and Historical Change," by E. H. Erickson, in *The Psychoanalytic Study of the Child.* New York: International Universities Press, 1945.

[5] See *Group Psychology and the Analysis of the Ego*, by Sigmund Freud. Philadelphia: Liveright, 1949.

therapy to two or more persons simultaneously. . . .''[1] Miller and Baruch forthrightly say: ''The process of psychotherapy by the group method is essentially the same as that for individual therapy.''[2]

On the negative side, we find a number of opinions, Moreno[3] complains that psychoanalytic principles have been inappropriately applied to groups. Slavson, quoted above, states: ''. . . the dynamics of group therapy, although analogous, are vastly different from those in individual therapy.''[4] Joel and Shapiro comment, ''Group therapy is not mass individual therapy.''[5] Meiers agrees, stating, ''Group therapy is not a linear multiplication of individual therapy.''[6]

*Definitions.*—A number of attempts have been made to define group psychotherapy. That some concern exists with reference to an adequate formulation of the term is evident from some quotations. Cotton states: ''Group psychotherapy has never been adequately defined.''[7] Renouvier says, ''Group therapy is the collective name for various methods which often contradict each other.''[8] Hulse comments, ''Group psychotherapy is a not-too-well-defined method embracing a number of different procedures that often have little in common.''[9] Ackerman states, ''Group therapy is as yet inadequately defined encompassing a variety of methods as different in concept as the men who practise them.''[10]

[1] See *The Practice of Group Therapy*, by S. R. Slavson. New York: International Universities Press, 1951.

[2] See ''Psychological Dynamics in Allergic Patients as Shown in Group and Individual Psychotherapy,'' by H. Miller and Dorothy Baruch. *Journal of Consulting Psychology*, Vol. 12, 1948, pp. 111–115.

[3] See ''Open Letter to Group Therapists,'' by J. L. Moreno. *Sociatry*, Vol. 1, 1947, pp. 16–30.

[4] See *The Practice of Group Therapy*, by S. R. Slavson. New York: International Universities Press, 1951.

[5] See ''Some Principles and Procedures for Group Psychotherapy,'' by W. Joel, and D. Shapiro. *Journal of Psychology*, Vol. 29, 1950, pp. 77–88.

[6] See ''Thoughts on Recent Advances in Group Psychotherapy,'' by J. I. Meiers. *Group Psychotherapy*, Vol. 3, 1950, pp. 241–245.

[7] See ''Group Psychotherapy: An Appraisal,'' by J. M. Cotton, in *Failures in Psychiatric Treatment*, edited by P. Hoch. New York: Grune & Stratton, 1949.

[8] See ''Group Psychotherapy in the United States,'' by P. Renouvier. *Sociatry*, Vol. 2, 1948, pp. 75–83.

[9] See ''Group Psychotherapy with Soldiers and Veterans,'' by W. Hulse. *Military Surgery*, Vol. 103, 1948, pp. 116–121.

[10] See ''Group Psychotherapy from the Viewpoint of a Psychiatrist,'' by N. W. Ackerman. *American Journal of Orthopsychiatry*, Vol. 13, 1943, pp. 678–687.

In terms of formal definitions, we find a number of attempts. Ackerman makes the following statement: ". . . a systematic approach to the total personality, involving some degree of access to unconscious mechanisms and having the potentiality of basic change in the adaptive patterns of personality."[1] Cotton makes this formulation, "I would define group therapy as an attempt to reinforce and strengthen the individual's defenses against anxiety by identification with, analysis by, and support from the group."[2] Abrahams says, "Group therapy . . . refers to a group process led by someone significantly less involved in the pathology to ameliorate the problems of the group members in relation to themselves and society."[3] Slavson offers the following definition: "Group therapy . . . is treatment in which no discussion is initiated by the therapist and in which interpretation is given rarely and only under specific conditions."[4] A final definition is offered in a War Department bulletin, "In a broad sense, any procedure which tends to improve the mental health of more than one person is group psychotherapy."[5]

It appears that none of these definitions is completely satisfactory in conveying an exact sense of group psychotherapy as it is generally understood. A better idea of this objection is gained by a rapid survey of a number of different techniques that have been labeled as group psychotherapy.

*Forms of Group Psychotherapy.*—It would be impossible to review every suggested method of group psychotherapy, but we shall highlight some suggested techniques, especially with reference to their unique characteristics.

[1] See "Some General Principles In The Use of Group Psychotherapy," by N. W. Ackerman, in *Current Therapies in Personality Disorders*, edited by B. Glueck. New York: American Psychopathology Association, 1946.

[2] See "Group Psychotherapy: An Appraisal," by S. M. Cotton in *Failures in Psychiatric Treatment*, edited by P. Hoch. New York: Grune and Stratton, 1949.

[3] See "Group Psychotherapy: Implications for Direction and Supervision of Mentally Ill Patients," by J. Abrahams, in *Mental Health Nursing*, edited by T. Muller. Washington: Catholic University of America, 1949.

[4] See *The Practice of Group Therapy*, by S. R. Slavson. New York: International Universities Press, 1951.

[5] See *Technical Bulletin 103*, published by the U. S. War Department, Oct. 10, 1944, pp. 1–7.

1. *ABC.* This method, primarily used with psychotics, requires the members to write letters of the alphabet on blackboards coöperatively to stimulate mutuality of relationships.[1]

2. *Activity Group Therapy.* Used primarily for youths in their latency, this method gives subjects wide limits of permissive behavior in a protected environment.[2]

3. *Auroratone.* Colored, non-objectve films are shown to the accompaniment of soft, sad music.[3]

4. *Behind-the-Back.* A subject sits with his back to the rest of the group while they discuss him as though he were not present.[4]

5. *Bibliotherapy.* Patients read material from a text and then discuss it.[5]

6. *Case Histories.* The therapist reads a case history of one of the group, who is not identified, and leads subsequent discussion.[6]

7. *Circular Discussions.* This method, used with variations by Freudians, Rogerians, and Adlerians, has the group meeting in a circle for the purpose of verbal interaction.[7, 8, 9]

8. *Class method.* This method, under a number of variations, is essentially a lecture.[10, 11, 12]

9. *Co-therapist.* A variation of the circular discussional method; there are two rather than one therapist.[13, 14]

[1] See "Review of A Year of Group Psychotherapy," by J. R. Jacobson and Katherine W. Wright. *Elgin St. Hospital Papers,* Vol. 5, 1944, pp. 26–42.

[2] See "Some Elements in Activity Group Therapy," by S. R. Slavson. *American Journal of Orthopsychiatry,* Vol. 14, 1944, pp. 578–588.

[3] See "Audio-Visual Aids for Mental Hygiene and Psychiatry," by E. Katz. *Journal of Clinical Psychology,* Vol. 3, 1947, pp. 43–46.

[4] See "The Behind-Your-Back Technique in Group Psychotherapy," by R. J. Corsini. *Group Psychotherapy,* Vol. 6, 1953, pp. 102–109.

[5] See "Didactic Group Psychotherapy," by J. W. Klapman. *Diseases of the Nervous System,* Vol. 11, 1950, pp. 35–41.

[6] See "The Dynamics of Group Psychotherapy and Its Application," by L. Wender. *Journal of Nervous and Mental Diseases,* Vol. 84, 1936, pp. 54–60.

[7] See "The Unique Social Climate Experienced in Group Therapy," by R. Dreikurs. *Group Psychotherapy,* Vol. 3, 1951, pp. 292–299.

[8] See "Group Analysis," by S. H. Foulkes, and Eve Lewis, *British Journal of Medical Psychology,* Vol. 20, 1944, pp. 175–184.

[9] See "Group Centered Psychotherapy," by N. Hobbs in *Client-Centered Therapy,* by C. R. Rogers. New York: Houghton Mifflin, 1950.

[10] See "The Use of General Semantics and Korybskian Principles as an Extension Method of Group Psychotherapy in Traumatic Neuroses," by D. M. Kelley. *Journal of Nervous and Mental Diseases,* Vol. 114, 1951, pp. 189–220.

[11] See "Group Therapy and the Psychiatric Clinic," by L. C. Marsh in the *Journal of Nervous Diseases,* Vol. 82, 1935, pp. 381–393.

[12] See "The Group Treatment of Dementia Praecox," by E. W. Lazell. *Psychoanalytic Review,* Vol. 8, 1921, pp. 168–179.

[13] See "The Use of Co-therapists in Group Psychotherapy," by W. H. Lundin and B. M. Aronov. *Journal of Consulting Psychologist,* Vol. 16, 1952, pp. 76–80.

[14] See "A Philosophical Basis for Brief Psychotherapy," by C. A. Whitaker, J. Warkentin, and Nan Johnson. *Psychiatric Quarterly,* Vol. 23, 1949, pp. 439–443.

10. *Dramatizations.* In this method, the patients write and act out plays.[1, 2]

11. *Family Counseling.* The adult members of families present their problems to the counselor who leads the group in discussion, and, after also interviewing the minor members of the families, gives his counsel.[3]

12. *Lectures with aids.* The therapist uses visual aids such as films, slides, or posters to supplement his lecture.[4, 5, 6]

13. *Leaderless therapy.* The leader assumes his place in the group as another member and takes no especial responsibility.[7]

14. *Mechanical group therapy.* Recorded messages of a highly repetitive type are played over a loud speaker system.[8]

15. *Multiple therapy.* Two or more therapists meet with one patient.[9]

16. *Music Therapy.* The members of the group either play instruments or listen to music.[10]

17. *Projective Methods.* The members of the group produce drawings which are analyzed by the other members.[11]

18. *Psychodrama.* This is a class of methods involving spontaneous interactions in situations having personal meaning to the protagonist.[12]

19. *Psychodramatic Group Therapy.* This is a cross between the circular discussional method and psychodrama; the members discuss and

[1] See "The Drama as a Therapeutic Measure in Adolescents," by F. J. Curran. *American Journal of Orthopsychiatry*, Vol. 9, 1939, pp. 215–231.

[2] See "Playwriting and Acting as Diagnostic Therapeutic Techniques with Delinquents," by R. Lasaner. *Journal of Clinical Psychology*, Vol. 3, 1947, pp. 349–356.

[3] See "Family Group Therapy in the Chicago Community Child Guidance Centers," by Rudolf Dreikurs. MENTAL HYGIENE, Vol. 35, 1951, pp. 291–301.

[4] See "A Method of Group Therapy," by M. C. Bettis in *Diseases of the Nervous System*, Vol. 8, 1947, pp. 235–246.

[5] See "The Use of Pictorial Images in Group Therapy," by M. Prados. *American Journal of Psychotherapy*, Vol. 5, 1951, pp. 196–214.

[6] See "Visual Aids in Group Psychotherapy for Veterans with Psychosomatic Complaints," by M. I. Stein, *Journal of Clinical Psychology*, Vol. 4, 1946, pp. 206–211.

[7] See "Intra-Group Tensions: Their Study as a Task of the Group," by W. R. Bion and J. Rickman. *Lancet*, Vol. 245, 1943, pp. 678–681.

[8] See "Mechanical Group Therapy," by E. Schmidhofer. *Science*, Vol. 115, 1952, pp. 120–125.

[9] See "Techniques and Dynamics of Multiple Psychotherapy," by R. Dreikurs. *Psychiatric Quarterly*, Vol. 24, 1950, pp. 788–799.

[10] See "The Use of Music in Group Therapy," by S. D. Mitchell and A. Zanker. *Journal of Mental Science*, Vol. 94, 1948, pp. 737–748.

[11] See "Psychological Dynamics in Allergic Patients as Shown in Group and Individual Psychotherapy," by H. Miller and Dorothy Baruch. *Journal of Consulting Psychology*, Vol. 12, 1948, pp. 111–115.

[12] See "Psychodrama and Group Psychotherapy," by J. L. Moreno. *Sociometry*, Vol. 9, 1946, pp. 249–253.

act out their problems with minimum direction and without the use of trained assistants.[1, 2, 3]

20. *Puppets.* The therapist has the puppets re-enact situations believed to have meanings for the subjects.[4]

21. *Public Speaking.* The subjects lecture on topics best known to themselves.[5]

22. *Round table.* Six subjects sit about a table and discuss their problems while they are watched and listened to by another group in a sound proof room.[6]

23. *Social Clubs.* Patients in a mental hospital meet for the purpose of social interaction and to promote worthwhile activities.[7]

24. *Sociodrama.* A situation is enacted believed to have relevant meaning for the members of the audience.[8]

25. *Will-training.* Used primarily with psychotics in remission, the members engaged in highly structured discussions based on a text which emphasizes semantic controls.[9]

*Towards a Definition.*—An adequate definition must include many activities believed to be therapeutic in the restricted sense of most of these methods, but must also exclude cognate activities. It is for this reason that the War Department's definition is unsatisfactory, since it is so general as to encompass a great variety of activities not usually accepted in a restricted sense of the term. The other suggested definitions seem to be inadequate because they do not set up sufficient conditions for determination of class memberships.

There appear to be four essential elements that a satisfactory definition must include. There seems to be a necessary

[1] See "A Simplified Psychodramatic Approach in Group Therapy," by R. O. Boring, and H. L. Deabler. *Journal of Clinical Psychology*, Vol. 7, 1951, pp. 371–375.

[2] See "The Method of Psychodrama in Prison," by R. J. Corsini. *Group Psychotherapy*, Vol. 6, 1953, pp. 102–109.

[3] See "A Modified Psychodramatic Technique for Rehabilitation of Military Psychoneurotics," by J. Shor. *Sociatry*, Vol. 1, 1948, pp. 414–420.

[4] See "Group Activities on a Children's Ward as Methods of Psychotherapy," by Lauretta Bender. *American Journal of Psychiatry*, Vol. 93, pp. 151–173, 1937.

[5] See "Origins and Development of Group Psychotherapy," by J. I. Meiers. *Sociometry*, Vol. 8, 1945, pp. 499–534.

[6] See "The Round-table Technique in Group Psychotherapy," by W. W. McCann. *Group Psychotherapy*, Vol. 5, 1953, pp. 233–239.

[7] See "A New Form of Group Psychotherapy," by J. A. Bierer. *Lancet*, Vol. 245, 1943, pp. 799–800.

[8] See "Sociology and Sociodrama," by J. L. Moreno. *Sociatry*, Vol. 2, 1948, pp. 67–68.

[9] See *Mental Health In Nursing*, edited by T. Muller. Washington: Catholic University of America, 1949.

element of *intentionality* or formality in group therapy. A definition that included this limiting concept would distinguish between such cognate activities as a play group and play therapy, theatricals from psychodrama, and a seminar from a circular-discussional therapeutic group. This concept implies an agreement to participate in therapy, without regard to the quality or value of the experience. It excludes a variety of group situations such as movies, sports, social clubs, or games, no matter how important, valuable, useful, or beneficial they may be to the psyche. We shall not try, however, to determine the degree or the kind of intentionality nor the parties to the agreement since this is a question that is moot.

An intention to participate in group therapy, even if shared by all members, may not be a sufficient condition to establish group therapy as a working concept, since the intention must lead to some kind of action different from that which would obtain had not the intention been made. In some institutions, for example, a certain activity is continued in exactly the same fashion as before, but is now labeled "therapeutic." This is an example of a difference that makes no difference.

The essential difference is in *social relationships*. The nature of the new relationships cannot be spelled out here in detail, but it is evident that they must be of the kind believed to effect therapeutic improvement. No fewer than 166 processes believed to effect therapeutic gains have been located, which may indicate the variety of mechanisms of personality amelioration.[1]

A third necessary concept for group psychotherapy is that of *protection*. Since the group situation according to the second condition becomes different from what it would ordinarily be, it means that the individual members are in a new atmosphere of relationships of the kind not ordinarily effected. A certain freedom of verbal or motor behavior exists, in which the individuals are permitted latitudes not ordinarily encountered. The person is free to explore himself and his environment in a permissive and accepting atmosphere.

A fourth necessary ingredient has an *economic* aspect. The

[1] "Mechanisms of Group Psychotherapy: Processes and Dynamics," by R. J. Corsini and Bina Rosenberg. To be published in the *Journal of Abnormal and Social Psychology*, November, 1955.

intention, the change in relationships and the protection of the group are for the purpose of attaining certain benefits which are not necessarily exclusive to the form of the new arrangement. Children can develop their personalities just as well in unsupervised playgrounds; adolescents gain understanding from gangs; adults in fraternities and seminars learn more about themselves. There should be no indication that the benefits from group therapy are exclusive to therapy, nor that they are qualitatively different. The difference is one of economy of time and effort. It must be accepted that the reason for the establishment of an artificial environment is for the purpose of attaining benefits, available elsewhere, more quickly, more easily and hence more cheaply.

*A Definition of Group Psychotherapy.*—On the basis of the foregoing discussion, based on analysis of the literature and on personal biases, the following definition is offered:

*Group psychotherapy is the intentional establishment of a protected environment in which social relationships are fostered of a kind presumed to result in rapid ameliorative personality changes.*

*Discussion.*—It is evident that this rigorous definition does not include all of the methods listed and described above. It must also be evident that neither the form of the group, nor the intention, nor the interactions, nor the results are sufficient for qualification. Both the spirit and the behavior must align in a consistent ongoing movement.

In terms of methods cited, the following, in their pure form, do not appear to be group psychotherapy within the strict meaning of the definition: Auroratone, the class method, lectures with aids, mechanical group therapy, music therapy, or puppets. These further methods seem to be questionable: bibliotherapy, dramatizations and public speaking. There is absolutely no intention of evaluating these activities, many of which are possibly extremely useful and socially valuable. We are here concerned with classifying, not judging.

It may, perhaps, be necessary to discuss the exclusion of the class method which is possibly the most popular form of activity called "group therapeutic" and which historically is the first of the group methods. It is evident that this method with its absence of interactions, with no requirement for pro-

tection, and with no evidence of economy of effects of personality amelioration is really education, not therapy.[1]

SUMMARY

We have examined various opinions with reference to a definition of group psychotherapy; and with the intention to establish a fairly rigid set of criteria, following an analysis of actual behavior in groups called therapeutic, a definition has been constructed which has four elements: (1) intentionality or formality; (2) changes in social relationships of a type calculated to produce ameliorative personality changes; (3) the establishment of a protected environment and (4) efficiency of change.

[1] See "Education and Therapy," by R. J. Corsini. *Journal of Correctional Education*, Vol. 4, 1952, pp. 24–26.

# THE DEVELOPMENT OF THE CONCEPT OF MENTAL HYGIENE

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THE concept of mental hygiene is a relatively recent one, having come into usage early in this century. Strictly speaking, it began in 1908 when Clifford Beers published a book called *A Mind That Found Itself* [1] which will be discussed below. However, before attempting to trace the growth and application of this term, mention should be made of a few individuals whose work and philosophy was such that if the term "mental hygiene" had existed during their lifetimes it might appropriately have been applied to their activities.

First among these was Hippocrates, a physician of ancient Greece who lived in the fifth century, B.C., and who is credited with making the first attempt to apply scientific methods to the treatment of disease, including mental disease. His contention was that all diseases were natural phenomena and not the result of mystical, magical, religious, or supernatural influences. Observation, classification, diagnosis, and treatment based upon the above prerequisites were the revolutionary steps advocated by Hippocrates.

Two other physicians who had a mental-hygiene approach to mental illness were Aurelianus and Galen who lived in the first and second centuries, A.D., respectively. Aurelianus made eloquent pleas for the use of gentle measures, and the abolition of restraints and brutality in the treatment of the mentally ill. Their approach and their keen insight into mental disorders were remarkably modern when one considers that they lived some eighteen hundred years ago. The great contribution of these men was that by and large they repudiated magic and religion in their approach to disease, and attempted to substitute observation, reason, and pragmatism in their place. But after Galen's death, this philosophy was stamped

[1] *A Mind That Found Itself*, by Clifford W. Beers. New York: Doubleday, Doran and Co., 1939. (30th Anniversary Edition.)

out and history shows that from that time until the eighteenth century, physicians surrendered their mental patients into the hands of priests. As a result, the Hippocratic view that mental disease was strictly a natural phenomenon was largely forgotten.

It was not until the time of the French Revolution that the mental-hygiene point of view reappeared in the work of persons like the eminent French physician, Philippe Pinel. In 1792, the revolutionary government placed him in charge of the Bicêtre, the large Paris hospital housing insane men, and there he was able to apply his "moral treatment" in an extensive and dramatic manner. Two years later he was transferred to the Salpetrière, the women's asylum, where he continued his constructive work. It was he who first ordered that chains and other shackles be struck off the "raving lunatics." That it took a strong conviction and the courage to act on that conviction appears obvious when one considers the times in which he lived. In this connection, one needs to be reminded that the history of medicine indicates that some of the strongest opposition to medical progress has come from physicians. Pinel's radical measures also met with violent criticism and resistance from the medical fraternity of his day. His colleagues as well as non-medical persons predicted that the "madmen" would tear Pinel and the guards apart if the chains were removed. History proved otherwise.

About the time that Pinel was pushing his reforms in France, three other men stand out as leaders in the mental hygiene work of that time. One was Benjamin Rush, the American surgeon who attempted to use the rational approach to mental disease of his famous forebear, Hippocrates. Although some of Rush's methods, particularly his extremes of purgation and blood-letting, were hardly therapeutic, he helped to focus attention on a more rational treatment of the insane in the United States. However, some of his other treatment devices, such as dousing mental patients with buckets of ice-cold water, seem to involve a principle that is in common usage today—namely, shock therapy. His pioneering book, *Medical Inquiries and Observations Upon the Diseases of the Mind*, published in 1812, was the first systematic and influential work in the field of psychiatry by an American.

Another name that stands out is that of William Tuke, who

was not a physician but a merchant and a Quaker. His pioneering work in England could properly be called mental hygiene both in scope and method. Although his reform was less dramatic than that of Pinel, the York Retreat which he founded in 1792 (exactly the same year that Pinel took charge of the Bicètre) set the example for an institution in which mental patients were treated kindly as such human beings.[1] It demonstrated that there was no need for dark cells and brutal restraints in the handling of such patients. Another important contemporary of Pinel, Rush, and Tuke was Vincenzo Chiarugi of Florence, who actually began his reform work in this field a little earlier than they did.

A person of more recent times who needs mentioning is Sigmund Freud. His monumental work on the study and treatment of the neuroses is too well known to require elaboration here. However, the fact that interests us is that the mental-hygiene approach which permeated all his work had a tremendous influence on the development of a mental-hygiene point of view all over the world and particularly in the United States.

The question which arises at this point is: When did the term *mental hygiene* first appear in print? As far as I have been able to determine, it was first used by a physician named William Sweetster, in a book published in 1843 with the long title: *Mental Hygiene or an Examination of the Intellect and Passions Designed to Illustrate Their Influence on Health and the Duration of Life.* In this book the author described how unpleasant "passions" (emotions) interfere with bodily functions.

In 1860 another book appeared, this one by William M. Connell with a somewhat shorter title called: *How to Enjoy Life or Physical and Mental Hygiene.* And finally, in 1863 Isaac Ray, one of the thirteen founders of the Association of Medical Superintendents of American Institutions for the Insane (now the American Psychiatric Association) published a book called simply, *Mental Hygiene.*

One of the surprises in preparing this report was that the term *mental hygiene* does not appear in the comprehensive and authoritative *New English Dictionary* (sometimes known

[1] Although founded in 1792, the York Retreat did not begin to accept patients until 1796.

as the Oxford Dictionary), nor in its *Supplement* of 1933. However, a few quotations from this dictionary of the term *hygiene* may be of interest.

The earliest reference to the word *hygiene* appeared in 1597 in Gulleneaus French *Chirurgery:* "hygiena . . . which instructeth how we should continuallye preserve our presente health." In 1729, Chambers in *Cyclopedia* states that, "hygiene is that branch of medicine which considers health." And in 1874, the following appears in Nahaffy's *Social Life of Greece;* "Greek medicine rather started from hygiene than from pathology." The current definition of hygiene in the *New English Dictionary* states: "That department of knowledge or practice which relates to the maintenance of health; a system of principles or rules for preserving and promotion of health; sanitary science."

The term *mental hygiene* has been variously defined by a number of authors since the beginning of the mental hygiene movement in 1908. A few of the definitions and other statements which throw light on the definition follow.

The earliest statement that I was able to find was in the *Proceedings of the Mental Hygiene Conference and Exhibit* of November 1912, in which the chief objects of the three-year-old National Committee for Mental Hygiene are listed as follows:

> "To work for the protection of the mental health of the public; to help raise the standard of care for those threatened with mental disorder or actually ill; to promote the study of mental disorders in all their forms and relations and to disseminate knowledge concerning their causes, treatment and prevention; to obtain from every source reliable data regarding conditions and methods of dealing with mental disorders; to enlist the aid of the Federal Government so far as may seem desirable; to coördinate existing agencies and help organize in each State in the Union an allied but independent Society for Mental Hygiene similar to the existing Connecticut Society for Mental Hygiene."

This list of objectives of over forty years ago gives us one of the best definitions of mental hygiene, and by and large the same definition has persisted to the present day. In this definition we find that mental hygiene involves three basic principles: prevention of mental disorders, the best possible treatment for the mentally ill, and research into the causes of such illnesses. Running through the three major programs is a strong emphasis on educating the public and on social action.

Another statement which in turn gives us a rather amazing definition of mental hygiene appears in a little book published by a remarkable woman named Lillien J. Martin, who in 1917, at the age of sixty-six, retired from her post as psychology professor at Leland Stanford Junior university and started a new and long-lasting career as a consulting psychologist in San Francisco.

> "The aim of the mental hygienic adviser is to decrease the mental disturbances growing out of a severe emotional strain; to banish abnormal persistent ideas; to do away with some of the mental disturbances of the stress of adolescence, change of life, and old age; to increase a person's power along lines of observation, attention including concentration, memory and will; to eliminate injurious mental and physical habits; to get rid of distressing dreams and sleeplessness; to destroy the painful and paralyzing mental after-effects which sometimes follow successful operation and cure of diseases; and to prevent and overcome the formation of alcohol and drug habits.
>
> "To assist in the protection, proper care and education of insane and feeble-minded persons.
>
> "To aid mothers and teachers in educating and managing, not alone their nervous children, but also those who are healthy, through applying the results of recent investigations in psychology along the lines of heredity and mental diseases.
>
> "To help in the personal application of some of the more recent studies of unnecessary fatigue.
>
> "To assist students and others to adjust themselves to their work, and to aid in the selection or change of a vocation; in general, to help people to increase their efficiency and happiness."[1]

Richard Paynter, a clinical psychologist writing almost twenty years after the beginning of the mental hygiene movement, attempts to define mental hygiene and also to trace the development of the term. His definition, which is derived from the statement quoted below, is of interest because it reflects the confusion of his day regarding the meaning of mental hygiene. In writing of the mental hygiene worker, he stated in part:

> "We all know that the technological (clinical) worker may be interested in discerning things in a particular case, as the scientific worker discovers facts from larger groups for application to particular cases. Nor are all good workers balanced by these two types of activities, the former may be totally uninterested in science, and the latter may be devoted to it. Here as elsewhere, *mental hygiene is what the worker makes it.*"[2]

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[1] See *Mental Hygiene—Two Years' Experience of a Clinical Psychologist*, by Lillien J. Martin. Baltimore: Warwick and York, 1920, pp. 1–2.

[2] See "The Clinical Psychologist at Work," by Richard H. Paynter. *Personnel Journal*, 6:288. (Italics mine.)

Another definition, and one which is typical of those appearing during the past two decades, is that of Clara Bassett which states:

> "Mental hygiene is that growing body of knowledge and techniques which has for its purpose the understanding of the evolution of human personality; the promotion of mental health as an expression of the highest development and integration possible, at each age level, of the physical, emotional and mental powers of personality; the study, treatment and prevention of emotional and behavior disorders, which preclude the happy and effective individual or social functioning of personality, as well as of the more radically incapacitating nervous and mental diseases and defects; the efficient organization and operation of community facilities which may be necessary for the achievement of these aims and the progressive modification of social institutions and agencies which vitally affect the mental health of large groups, so that the principles, methods and practices in use may more successfully conserve mental health and contribute to the growth of personality." [1]

More recently, the current unabridged-edition of *Webster's New International Dictionary* defines mental hygiene as, "The science and art of maintaining mental health and preventing the development of insanity and neuroses."

The late Adolf Meyer, for many years one of the nation's leading psychiatrists and faculty member of Johns Hopkins School of Medicine, is credited by most authorities with suggesting in 1908 that the term mental hygiene be applied to the program of reform and education which is now known as the mental hygiene movement. Today mental hygiene covers a great deal of territory. Stated simply, mental hygiene means mental health or the rules by which mental health may be attained and maintained. It may be defined as the aggregate of measures designed to preserve mental health. More commonly, mental hygiene is thought of as those procedures devised for the prevention of mental ill health.[2]

This, of course, encompasses the whole gamut of dynamic psychology—all the relationships between individuals and between groups of individuals. From this point of view, mental hygiene concerns itself with broad and important problems of human behavior such as those of individual aggressions,

[1] See *Mental Hygiene in the Community*, by Clara Bassett. New York: Macmillan Co., 1934, p. 3.

[2] See "Mental Hygiene," by James V. Lowrey, in Margaret Hodges (Ed.) *Social Work Year Book 1951*. New York: American Association of Social Workers, 1951, p. 320. Also on page 346 in the article, "Mental Health," in Russell H. Kurtz (Ed.) *Social Work Year Book 1954*, Lowrey states, "The term 'mental health,' is replacing 'mental hygiene'..."

and of mass aggressions including the causes and psychological effects of wars, and of the exploitation of one group or nation by another. It is concerned with man's inhumanity to man and with his tenderness, dignity, and self-respect.

Thus mental hygiene includes the study, analysis, and amelioration of certain aspects of politics, of religion, and of government. It is concerned with mental "public health." Albert Deutsch makes this quite clear when he states:

> "A world of peace and freedom, from which the twin specters of war and insecurity will be banished, a world of equal opportunity, where people will be freed from stunting inhibitions and guilt feelings arising from outworn prejudices and taboos, a world where children may lead healthy, happy lives and grow into useful, well adjusted citizens, where the personality is permitted to develop naturally and freely, where the individual is given a sense of personal worth and dignity, and where his activities and ambitions are integrated with the development of group life—such is the goal toward which mental hygiene must strive."[1]

These are the broad, panoramic, or public-health aspects of mental hygiene. A second aspect of mental hygiene is concerned with the understanding of the individuals with whom we come in contact and, consequently, with understanding oneself. It involves teaching people how to accept themselves as they are, how to recognize reality rather than live in a world of wishful thinking and fantasy. It tries to help people help themselves solve many of the problems which beset them, to get the utmost out of themselves and out of the world around them—to lead more personally satisfying and more socially constructive lives. In the first aspect, mental hygiene is preventive; in the second aspect, it is clinical and experimental. It is obvious that both aims are closely connected, as the individual who is at peace with himself, who is emotionally stable, stands less chance of a breakdown than the one who is beset by tensions and conflicts within himself.

The answers to mental health and mental ill health have been sought by people since the beginnings of recorded history. However, it was not until early in the twentieth century that the mental hygiene movement really got underway. This movement received its main impetus from the publication in 1908 by Clifford Whittingham Beers, a former mental patient, of his classic book, *A Mind That Found Itself.*

[1] See *The Mentally Ill in America,* by Albert Deutsch. New York: Doubleday, Doran and Co., 1937, p. 496.

In a large part as a result of this remarkable book, in 1908 a state mental hygiene society was established in Connecticut. The following year on February 19, 1909, the National Committee for Mental Hygiene was founded. From that time until 1950 it operated as a non-profit, voluntary agency composed of a nation-wide membership of businessmen, clergymen, educators, social workers, physicians, psychologists, and others vitally interested in promoting sound mental health. In September 1950, in order to strengthen the attack on the serious mental health problem in the nation, it merged with two other voluntary organizations, the National Mental Health Foundation and the Psychiatric Foundation, to form the National Association for Mental Health.

During more than four decades, the National Committee for Mental Hygiene carried out a continuous program of education for positive mental health and its activities played the major rôle in defining the term *mental hygiene* and in disseminating this concept all over the world. Its successor, the National Association for Mental Health, continues its unending struggle against the scourge of mental and emotional disorders. Its small-paid professional staff and its devoted volunteers are consulted frequently by lay organizations, professional groups, and by state, national and international public officials. Among other things, it publishes pamphlets and reading lists on various aspects of mental hygiene, and two outstanding periodicals: *Mental Hygiene,* a quarterly for professional workers, and *Understanding the Child,* a quarterly publication for parents and school teachers.

# BOOK REVIEWS

PARENT COÖPERATIVE NURSERY SCHOOLS. By Katharine Whiteside Taylor. New York: Bureau of Publications, Teachers College, Columbia University, 1954. 252 p.

When Katharine Taylor told me she was writing a book about parent coöperative nursery schools, I thought, "Surely there is no one better equipped to do this." Since 1927, Dr. Taylor has been working with groups of parents and children, helping them to live together with the increased ease that comes when parents grow in acceptance and understanding.

Dr. Taylor is at present Supervisor of Parent Education in the Baltimore Public Schools. Among her past experiences, during World War II, in her rôle of Consultant in Family Life Education in the Seattle Public Schools, she organized and developed an extensive program of parent coöperative play groups. It was there I first met her and became aware of her very special qualities and qualifications.

This book is like an extension of herself. It is gentle and yet compelling, written with humor and yet with dignity.

Against the background of coöperative nursery schools as a "new folk movement," Dr. Taylor recognizes the "young mother and her problems." She goes on to present a wealth of information concerning the organizing and running of such groups. This information is practical and useable, detailed plainly so that it can be adapted to meet the needs of those seeking to know about budgets and schedules, about securing a teacher, about parent's jobs, about finding a site and equipping it, about standards of health, legal considerations, and the myriad questions that are bound to confront and challenge not only the parents who are setting out on coöperative ventures, but also the professional people in schools and colleges to whom these parents turn for advice.

When it comes to discussing the daily activities of both parents and children, the book, like the author, moves gracefully in tone and mood and substance. It is full of appreciation of those small, important things eye-high to children which so often escape the adult's gaze. It is full of material that will help parents and teachers to project themselves into the minds and feelings of children. Take, for example, this brief excerpt from what the author calls an "inner monologue" through which a mother is fantasying and putting into her own words her feelings about how her child is feeling at the start of his nursery school career. "I am going to nursery school," she says. . . . "Mother

told Daddy that I would be off her hands every morning. Am I on her hands? The baby lies in her arms and sits on her lap. She is awfully busy since the baby came. She has her hands full. Full of me? Sometimes she says her hands are tied. That's funny. Daddy always says 'relax' when she says that. . . ."

Through such examples, and through illustrations that come alive as one reads, one gains the feeling that being a parent or a teacher, or both, is not only a thing of skill, but an art; not only a thing into which one puts knowledge but also into which one puts creativity and imagination. Dr. Taylor bridges the stretch that reaches from keen observations into empathy and sensitive insights. She draws people nearer to what she, herself, does and feels. Her idealism and faith lift the book above the practical so that it inspires as well as guides.

DOROTHY W. BARUCH

*Beverly Hills, California*

MAN'S CAPACITY TO REPRODUCE: THE DEMOGRAPHY OF A UNIQUE POPULATION. By Joseph W. Eaton and Albert J. Mayer. Glencoe, Illinois: The Free Press, 1954. 59 p.

This is a straightforward, succinct, and workmanlike little volume, whose title exactly states its contents. The problem is this: What are the maximal upward limits of human fertility? What is "normal" human reproductivity in the biological sense, when minimally interfered with by cultural factors? For the purposes of such an investigation, the Hutterites of North America offer an unusual opportunity for study. In this religious sect, there is little migration (and that easily ascertainable) to interfere with the demographic picture; no use of birth-control measures; a rural-farming society in which children are an asset; and a religiously-ordained communalism which minimizes the effects an economic differential might have upon fertility. The Hutterites consequently are reproducing themselves close to the theoretical maximum in all but the 15–19 age group.

The booklet proceeds in orderly fashion to discuss in turn the history of the group, the modern locale, the demographic records, and the methodology used. The Hutterites are remarkable in the stability of their population pyramids, with a relatively youthful age distribution from 1880 to 1950, a stable sex ratio, an unusual male life-expectancy, and a fertility ratio in 1950 (96.3 per hundred women) that is greater than that of any other known human population (the comparable U. S. figure is 42.3). The Hutterites are further interesting in having a "primitive" high fertility ratio, but a thoroughy modern low-mortality rate.

The study is a testing of a great many demographic "laws" hereto-

fore accepted as valid. The figures of Raymond Pearl on the number of copulations necessary to produce a live child are shown to be excessively high, and much exaggerate the difficulties of accomplishing pregnancies. The de Castro thesis that the hungry peoples of the earth are the most fertile is not borne out by the Hutterite study: neither vice, poverty, disease, nor war has been a factor in American Hutterite history. Had he known the Hutterite figures, the Rev. Mr. Malthus might have been even more pessimistic in his demography!

The value of this book is wholly incommensurate with its small length. The data it furnishes will be useful in all manner of future investigations: the testing of the demographic hypotheses of Riesman and others, the political and economic problems of Porto Rico, Java, India, China, and indeed much of the non-occidental world; and such facts as are instanced in this study have a definite bearing on many larger questions like mental health and war. We look with interested anticipation to the future publications of the Hutterite study group.

WESTON LA BARRE

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*Durham, North Carolina*

A COURT FOR CHILDREN (A Study of the New York City Children's Court). By Alfred J. Kahn. New York: Columbia University Press, 1953. 359 p.

The study was carried out under the auspices of the Citizen's Committee of New York City, Inc., an organization of lay and professional leaders devoted to the improvement of services for children, by the author of this book, an associate professor at the New York School of Social Work, Columbia University. Two of his previous studies—undertaken for and published by the same Committee—dealt with "Children Absent from School" and "Police and Children."

The present volume is of great importance far beyond its local scope and its necessarily ephemeral character (the report itself indicates that changes were made between the time of the study and the publication of the book, and it can confidently also be assumed that further improvements will be in effect by the time this review appears in print).

There are several grounds for the general value of the book: First—as a starting point for his study of the New York City Children's Court the author sets forth in considerable detail the historical development and the basic idea of the juvenile court, probation, and the mental health movement. He frequently refers to, and analyzes the present nationwide controversy regarding the nature and scope of juvenile courts: Should they be limited to purely legal functions,

*i.e.*, the finding of neglect and of delinquency, and, with the exception of probation, leave the disposition of cases to administrative bodies, such as state or local departments of welfare, or youth authorities and commissions? In view of the extremely serious aspects of some forms of current delinquency, how can juvenile courts combine their dual character of judicial authority and social agency? How can they—as chancery tribunals with emphasis on the *in loco parentis* concept—guarantee the constitutional rights of young defendants? How can probation be both a law-enforcement activity and a form of social case work?

Within the framework of such questions and with the goal of blueprinting "a sensitive and effective court for children," the author probes into the procedure, the machinery, the locality, the personnel, the attitude of the Children's Court of New York City. He puts a critical spotlight on the intake service and, in particular, the Bureau of Adjustment to which all cases of child neglect and only the less-serious delinquency cases are first referred with the view of adjusting the situation out of court. This is basically a sound idea, but the practice, according to the research findings, is only partly satisfactory, due primarily to lack of adequate staff and the limited scope of case coverage. In describing the court hearings, the study points up the wide-range variations of judges' attitudes and modes of procedure. For instance, some of the twenty judges make good use of the social study prepared by the probation officers and even consult actively with them on the cases, others emphasize the offense and show little insight into the underlying causes for the child's behavior; some make special efforts to interpret the case disposition to the clients, others just announce their decisions and create confusion and bewilderment among parents and children. The climate of the hearing, as created by the physical condition of the court room and the conduct of the court attendants, is scrutinized and not infrequently found unhealthy.

Two chapters of the study are devoted to the work of the probation department, dealing with "case study" and "probation as treatment." Case records are evaluated and samples quoted, staff qualifications and work conditions, especially salary systems, case work supervision, administrative leadership, clerical facilities, are reviewed and considerable short-comings discovered. The Bureau of Mental Health Services of the Court, providing diagnostic and treatment services, is appraised; but the Court's method of identification and referral of those who are most in need of psychiatric study or treatment is called "unorganized, random, and fortuitous." In order to bring about a better method of selection of children for needed psychiatric services, to develop methods of interpretation of such services to the

parents and children, and to demonstrate to the city authorities the need of these services, a special Court Intake Project was started during the time of the study through the initiative of the presiding justice, with the financial backing of several philanthropic foundations, and under the responsible auspices of an Advisory Committee consisting of leaders in the field of law, psychiatry, and social work. The author of the study considers the undertaking of this pilot project a very hopeful sign.

Finally, other services and resources available to the court, such as the Guidance Institute of Catholic Charities, the Jewish Board of Guardians, the Protestant Big Brother and Big Sister Movement, the shelter and detention facilities (especially Youth House and Girls Camp), intramural placement facilities, vocational guidance programs, etc., are described, and the lack of sufficient child-guidance centers and of a variegated institutional program is stressed.

A second reason for the universal value of this book is found in the applicability of many of its criticisms and even more so, of its recommendations for improvement, to the juvenile courts in other communities, and incidentally, not merely in large cities. This is particularly true, since, as the author explains, the New York City Children's Court does not present a uniform picture, if for no other reasons, owing to the differences in case load, quantity of staff, building facilities, and even procedure, in the five boroughs of New York City. Of the recommendations, only the most important can be mentioned: A unified intake service for all cases through a well-staffed Bureau of Applications and a uniform process of handling these cases from initial contact to disposition should be established. The Probation Department should be made into a qualified case work agency, with emphasis on counseling and guiding; this entails enlargement of staff and—simultaneously—a raising of qualifications, with the ultimate aim of appointing fully trained graduate social workers to positions of probation officers and supervisors. This, in turn, necessitates the assurance of a commensurate salary scale which will attract qualified personnel for the various levels of assignment; thus case loads would be reduced to a bearable maximum, and real supervision of the child on probation rather than a perfunctory "checking up" would be achieved; the in-service training program which was started in recent years should be intensified, and special case seminars be conducted by probation supervisors with the help of the court clinic staff and outside expert consultants; a liberal policy of educational leaves for attending courses at schools of social work should be initiated to raise the level of knowledge and competence of the staff; increased case consultation with psychiatrists should be made possible; the employment of qualified supervisors would afford the probation officers

guidance and efficient case supervision. In the matter of selection of judges, a somewhat modified form of the so-called "Missouri Plan" is proposed, namely the nomination of three candidates by a "Children's Court Judicial Commission," composed of representatives of appropriate legal bodies, (higher courts, bar association, and law schools) as well as the fields of welfare, education, mental hygiene, and medicine on a city-wide level, and the appointment by the Mayor of one of the three nominees. As the Standard Juvenile Court Act, prepared by the National Probation and Parole Association, spells out, "Juvenile Court Judges shall be selected with reference to their experience in and understanding of problems of family and child welfare, juvenile delinquency and community organization." The mental health program of the Court should expand both its diagnostic and treatment services and provide for case consultation with and in-service training of the probation staff. In respect to resources and facilities outside the Court's structure but essential for the proper operation of the Court, the following recommentations are made to the proper departments and agencies and to the community-at-large: expansion and improvement of temporary shelters for neglected children and detention for delinquents, development of more psychological testing and psychiatric diagnostic facilities to service the courts, expansion of public and voluntary community resources for psychiatric treatment of children, development of skilled vocational guidance and job placement facilities for boys and girls of school-leaving age, better liaison between school authorities and the courts, more and better foster homes to serve many kinds of children, particularly Negroes and those of other minority groups. Also, group residences and residential treatment homes in the city for teen-age boys and girls who cannot return to their families after institutionalization or who need such help in the transition to full adult responsibility for their own care, should be developed. The latter proposal, and criticism, which are oriented toward constructive helpfulness, in the opinion of your reviewer, refers to one of the most flagrant gaps of services from which practically every community suffers. Of the other recommendations for improvement, many, if not all, are equally valid for juvenile courts throughout the land.

Thirdly, the scope and method of the study, its scientific approach provide a brilliant example for this kind of practical research. With proper adaptation it can serve as a sample for other communities which have realized the need for improvement of their own services for children in trouble, and especially of their juvenile court. In this connection, the coöperative attitude of the New York City Children's Court itself, especially the Presiding Justice of the Domestic Relations Court (of which the Children's Court is a part), Judge John Warren

Hill, highlighted by the reforms effected even during the time of the study and immediately thereafter, the initiation of the study by a Citizens' Committee, and the services of a special advisory committee (in which the various disciplines which are operative in the Children's Court's activities were represented), should be mentioned as important features of the New York Study, worthy of emulation elsewhere.

Various characteristics of the "method of the study" are described in an appendix to the book, which also contains a bibliography.

In his foreword, Dr. Kenneth D. Johnson, Dean of the New York School of Social Work, himself a former juvenile court judge, and chairman of the Advisory Committee, calls the study an "unprecedented report." The preface of Justice Jerome Frank of the United States Court of Appeals, is a masterful essay on the rôle of the juvenile court in a democracy, in which he states, *inter alia*: "Far more direct and often far more significant than that of the United States Supreme Court is the influence on thousands of lives of the special courts for children."

A Public Affairs Pamphlet (No. 207), entitled "Children in Court," and prepared by Helen W. Puner, is largely based upon Dr. Kahn's book.

JOHN OTTO REINEMANN

*The Municipal Court of Philadelphia*

A SYNTHESIS OF HUMAN BEHAVIOR. By Joseph C. Solomon, M.D. New York: Grune and Stratton, 1954. 265 p.

Since the thirties, psychoanalytic thinking has shifted in emphasis from id-instincts to the ego and its drives and development. In this book, Dr. Solomon summarizes some current thinking in this area, and presents some original and provocative ideas of his own. The purpose of this new addition to the psychoanalytic bookshelf is nicely stated by Dr. Karl Bowman in the foreward:

> "In this book the author has attempted to categorize human behavior according to the growth of ego development. His codification pertains to physical maturation, and psychosexual and ego development. These stages are traced through infancy, early childhood, adolescence, maturity, and later aging."

In this purpose the author succeeds quite well. Beginning with the infant, Dr. Solomon traces the development of early ego autonomy, sphincter control, the development of speech, and the castration complex. After a discussion of the latency period and the resolution of the oedipus, the author discusses the sexual, social, occupational, religious, and home identities of the adolescent. He then treats the

problems of marriage and work in the adult and the egos of the young and the mature adult. The developmental process is completed with an excellent treatment of the middle years and old age.

Approximately half of this book is devoted to the development of the ego through the latency period. Of a total of 247 pages of reading matter, only approximately 80 pages are devoted to the adult, the middle years, and old age. This may represent a proper balance, for, as Dr. Bowman points out in the foreward, "... by the early twenties, the average young man or woman has attained a rather full maturation and personality development." There is, of course, no quarrel with this statement, but, in some respects, it is unfortunate that the author did not see fit to devote more space and material to the later years. The last two chapters, on the middle years and old age, are illuminating accounts of an area of development and maturation that is frequently neglected. The discussions of the menopause and the social attitudes toward the aged are particularly fine sections. It can be hoped that Dr. Solomon will someday expand these chapters into a book-length treatment of the problem of later maturity.

Throughout the book, the author makes use of the data and research from the areas of anthropology, sociology, and biology. These are fused with psychoanalytic theory and clinical material to present a unified picture of the development of the ego. Although there is a passing reference to Wundt in a footnote, the absence of any real contribution to this picture from the field of experimental psychology is obvious. This is all the more surprising since Dr. Solomon's orientation is essentially perceptual, an approach which has led to much fruitful material in contemporary experimental psychology.

This is a book that will be of interest to many well-read parents, as well as psychiatrists, physicians, psychologists, and social workers.

The "Table of Ego Organization" in the first chapter presents in tabular form ego development in both normal and abnormal growth and should prove to be an excellent learning device for students and practitioners in these professional fields. One cannot agree with all that Dr. Solomon has to say, but his book can be recommended as a stimulating and well-integrated treatment of material that is written with warmth and understanding.

PHILIP HIMELSTEIN

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INTRODUCTION TO PSYCHIATRY. By O. Spurgeon English, M.D. and Stuart M. Finch, M.D. New York: W. W. Norton & Company, Inc. 1954.

As stated in the preface, the authors undertook to write a psychoanalytically oriented textbook. Actually, it turned out to be a comprehensive textbook permeated not only with the Freudian teaching, but also with the Meyerian psychobiological concepts of psychology and psychopathology. On this sound scientific background, the authors more specifically expound the basic Freudian psychoanalytical teaching, as applied to the present day, generally recognized, principles of dynamic psychiatry. True to those principles, the authors prepare the student for a better understanding of the classical psychopathological syndromes, in introducing him to the fundamental knowledge on "the development and structure of personality" and on "the development of mental and emotional disorders." Again, in line with the recognition of the effects of childhood experiences on the function of the adult, child psychiatry is also given prominence in both place and content.

The chapter on "Personality Disorders" compares favorably with other textbook descriptions of deviations from the normal behavior pattern, formerly classified as "character disorders." The authors adopted the general classification of the American Psychiatric Association. Each category is succinctly, but more than adequately, discussed and illustrated with case histories.

Psychosomatic disorders are presented under the heading "Psychophysiologic Autonomic and Visceral Disorders." It seems to the authors "wiser," in accordance with the official classification of the American Psychiatric Association, to use the term psychophysiologic rather than the term psychosomatic. It is undoubtedly wise to be in harmony with the dominant concepts of the American Psychiatric Association. However, aside from that, I cannot see any scientific reason or any practical advantage of substituting the term psychophysiologic for that of psychosomatic. The latter denotes more comprehensively the possible happenings in a pyschosomatic condition: The reactions of organs to emotional disorders may be physiological, pathophysiological, and, as pointed out by the authors themselves, they also may eventuate in tissue damage. The term psychosomatic covers such organic reactions; obviously, the term psychophysiologic does not. It also appears to me noteworthy that the title of this chapter does not do full justice to it's content: While by far the largest part deals with reactions of visceral organs—under the specific control of the autonomic nervous system—the "Psychophysiologic musculoskeletal reactions" certainly illustrate the effects of

emotional disorders on organs under the dominant control of the cerebrospinal-voluntary-nervous system.

The chapter on "Principles of Psychotherapy" deserves particular recognition as sound and effective teaching: In the limited space of 42 pages, the authors describe succinctly, and yet with sufficient comprehensiveness, the various components entering into psychotherapy. Relatively considerable space is alloted to "Psychoanalytic Psychotherapy," that is "a psychoanalytically oriented type of treatment which has gradually evolved from attempts to provide a dynamically oriented therapy to a larger number of patients over a shorter period of time than can be provided with psychoanalysis." It is particularly useful, *in a textbook,* to discuss this type of treatment more comprehensively than the classical psychoanalytical therapy: the reason being that, undoubtedly, for the most part, this kind of psychotherapy, to a more or less degree, is currently used. The reader will find in this chapter brief, but very adequate descriptions of the basic mental mechanisms, as formulated more specifically by the psychoanalytical school of thought.

The standards courageously set by the authors for "qualifications of a psychiatrist" are high indeed. Let us hope that they will contribute to a better natural selection of prospective psychiatrists and deter from taking up psychiatry, as their life work, those students who think of treatment in psychiatry mainly in terms of an electric-shock machine. Here, again, the discussion is illustrated with case histories.

In conclusion, I am pleased to feel justified in recommending this textbook to medical students and to those who are interested in or just curious about the fascinating field of psychiatry.

SOLOMON KATZENELBOGEN

*Washington, D. C.*

MAN ABOVE HUMANITY: A HISTORY OF PSYCHOTHERAPY. By Walter Bromberg, M.D. Philadelphia: J. B. Lippincott Co., 1954. 342 p.

This book undertakes a presentation of the historical background of present-day psychiatry, the "chaotic field of mental healing." "The author has endeavored to present the currents, the movements, the individual figures in the long evolution of psychotherapy."

In 342 pages, it is impossible to do more than mention the origins, evolution, modification, and decline of currents and figures. The suggestion of superficiality is overcome through the many references to sources of information that are given throughout the book. At times the reading is retarded by an excess of qualifying adjectives

even though these may be desirable for the sake of accurate statement.

Some readers may be troubled by the inclusion of a liberal proportion of superstition, witchcraft, magic, and faith healing. Yet all of this is included in past and even present psychotherapy, and it is part of the heritage of medical theory and practice.

The first half of the book deals with the historical period intervening between the trephining of human skulls in the Stone Age and the "emergence of dynamic psychotherapy" in the middle of the nineteenth century. The remainder of the book deals with a correlation of concepts and events familiar to modern psychotherapists. No school of thought or practice is given undue space or emphasis, with the exception of that of Wilhelm Reich and his orgone therapy. Three pages are devoted to "orgone," "orgonotic charge," "bion," and the development of an orgone energy accumulator which released bio-energy "bound in characteriological armorings."

Critics of psychiatry are inclined to look for evidence of quackery. The present ban by the Food and Drug Administration on the publication or dissemination of any literature regarding the orgone energy-accumulator device or the use of this contraption could be cited as evidence in the criticism of psychiatrists and their methods to the detriment of valid psychotherapeutic endeavors.

In the foreword to this book Dr. Winfred Overholser remarks that the author has "through the years . . . evinced a deep interest in psychiatric history . . . He has now given us the fruits of his study and reflection in this comprehensive, thoroughly documented, clearly and interestingly written account of the evolution through the centuries of man's efforts to help his psychologically disturbed fellow man." I would subscribe to this appraisal and add that this book should be useful not only to psychiatrists and psychologists, but to anyone interested in historical developments.

GEORGE W. HENRY

*New York City*

PSYCHOANALYSIS AND THE EDUCATION OF THE CHILD. By Gerald H. J. Pearson. New York: W. W. Norton & Co., Inc. 357 p.

Dr. Pearson has always had the ability to organize material and to present it lucidly. He has done so again in this book, yet it is not nearly as easy to read as his previous writings. This is chiefly because of the complexity of the subject. Not even as skilled an author as Dr. Pearson could give a comprehensive exposition of the complexities of learning-problems and still keep it simple. An attempt at simplification could only have resulted in sacrifice of accuracy and comprehensiveness. Although it is a book that requires time for

study and thought, the reader will be repaid by the richness of content. It certainly should be read—and kept on hand for further reference—by anyone engaged in the practice of child analysis or in psychoanalytically oriented psychotherapy with children, as well as by educators. It brings together widely scattered reference material on learning-problems, besides the many original contributions derived from Dr. Pearson's long experience with children having such problems.

Part One, "Psychoanalysis and the Learning Process," reviews the psychoanalytic theories of personality structure and development, as a background for understanding how the child learns and how failures in various phases of personality development interfere with the learning process. For example, Dr. Pearson emphasizes that a well-organized ego and the establishment of supremacy of the secondary process (logical way of thinking) over the primary process (which operates via such illogical unconscious mechanisms as displacement, condensation, etc.) are essential in the child's development before he can learn with any success. Besides this general personality requisite for learning, individual differences in personality will affect interest or disinterest in a particular subject or ability to learn better by one method of instruction than another. For instance, a child with strong exhibitionistic tendencies may be expected to learn readily whenever dramatics can be used in teaching a subject; while a child whose drives are less exhibitionistic and more toward peeping to gratify sexual curiosity, would respond to teaching methods utilizing opportunities for scientific research. In other words, the child has greater interest and motivation for learning if the subject matter and method of instruction afford some gratification for his unconscious drives.

Ideally, then, instead of teaching all the children in a group the same things in the same way, educational methods should be varied to appeal to the differing unconscious drives of the individual children in a class. This is easy to say, but far from easy to do. As Dr. Person notes, we have tests which can furnish information about a child's mental ability, special aptitudes, deficiencies, etc., but none (not even with all our current projective techniques) that reveal such personality characteristics as he is describing. He mentions that some teachers may intuitively recognize a child's unconscious interests and motivations, but this intuitive understanding of the child is more likely when the teacher's unconscious wishes are akin to those of the child, and there may be complete lack of understanding if the child's unconscious drives are very different from those of the teacher.

Part Two is on "Ego Psychology and the Education of the Child."

It begins with descriptions of the defense mechanisms of repression, reaction formation, and sublimation, and discusses how these may operate for or against the child's learning. In general, from the viewpoint of ego psychology, failures in learning are to be regarded as failures in sublimation, while success in learning and creative productivity both depend upon sublimation of the instinctual drives. Dr. Pearson points out that neither extreme of progressive education or traditional education is favorable for a personality development that best enables a child to learn. Progressive education requires too little repression, thus interfering with sublimation, while traditional educational methods demand too strong repressions so that the child's energies are consumed in maintaining the repressions, instead of being free for deflection into sublimation and learning. What is needed is a type of education that requires an optimal amount of repression, which is, of course, the basis for sublimation.

Part Two also contains an excellent critique of physical education and the students' reactions to it, a fine statement of the effect of the relationship between teacher and child on the child's learning, and much other valuable material.

Part Three, "Psychoanalysis and the Development of the Moral Sense," focuses on the superego and the ego-ideal. Here it is stressed that since both ego and superego development begin in the preschool years, parental ways of training the child from infancy onward are extremely important. Dr. Pearson gives an excellent account of what the child needs from parents in order to learn that he is a separate person and to establish ego boundaries. These are prerequisites for superego formation, which is next discussed. Like Anna Freud, Dr. Pearson emphasizes the necessity for love between child and parents for the development of a superego which will enable the child to adapt to the social reality in which he must live, but which will not be a too severe and punitive superego. Since ego-ideals are formed somewhat later than other parts of the superego, not only parents but also teachers contribute to their development. The child tends to identify with teachers whom he likes and admires, and to acquire some of their characteristics by incorporating them as ego-ideals.

In a final chapter, Dr. Pearson states that this book is not intended to supplant the knowledge about children and their education which has come to us from research by child and educational psychologists, for he believes that we should try to synthesize and integrate the contributions of psychoanalysis and of these other investigations of child development and the learning process. This is a sound position. Child psychiatrists and psychologists need to be familiar with other psychological studies of learning-problems, as well as the psycho-

analytic ones, in order to diagnose the educational problems of children and to select the appropriate measures for treating them.

It is to be hoped that educators also will read what Dr. Pearson has written and try to apply some of his suggestions to school educational programs.

PHYLLIS BLANCHARD

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ANALYZING AND PREDICTING JUVENILE DELINQUENCY WITH THE MMPI. By Starke R. Hathaway and Elio D. Monachesi (Editors). Minneapolis, Minnesota: The University of Minnesota Press, 1953. 153 p.

The purpose of this book is to collect in one volume some of the more representative results of Minnesota Multiphasic Personality Inventory (MMPI) studies in juvenile delinquency. Seven studies are reproduced, preceded by an extended discussion of "Juvenile Delinquency and the MMPI" and followed by a brief appraisal of the significance of the findings in these studies. In each of these seven studies, the MMPI has been utilized as the sole test or as one of a number of personality inventories. As used in this compilation, the MMPI consisted of fourteen measures. Four of these are validating scales which are related to the accuracy and reliability of the subject's responses in the test, and the remaining ten of the most widely-used scales are related to various aspects of personality, such as introversion-extraversion, hypochondriasis, depression, psychopathic deviation, masculinity-femininity, psychasthenia, schizophrenia, paranoia, hysteria, and hypomania. The editors attempt, therefore, to justify the use of the MMPI in the revelation of personality types and characteristics that are delinquency-prone.

Although the editors readily admit that in certain respects the MMPI is not an ideal instrument for use with junior and senior high-school children, they still feel that its use at these levels is permissable. The main reasons for defending its use lie in the objective scoring of the test and in its suitability for large-scale administration. Therefore, the editors believe that such a test is needed to identify various subgroups of children that are more likely than others to become delinquent if one of the assumptions of the mental hygiene movement is to be realized, namely, the assumption that therapeutic work with individual children will decrease the likelihood of their later delinquency or mental illness. No claim is made, however, that the MMPI will point out the dilenquency-prone individual. Further justification for the utilization of the inventory is found in the results of these

seven studies, especially the general conclusion that "some of the patterns of symptoms seen in adult mentally ill patients are more common among juvenile delinquents than chance would suggest." (p. 136)

The major hurdle which the editors have to overcome is whether or not the scores of youths taking the MMPI can validly be contrasted with the norms developed for this test, since the MMPI was developed on the basis of the responses of adjusted and maladjusted adults. The editors maintain that there is no need for the establishment of youth norms for this test because our "culture only partially accepts the differences between youths and adults. . . . Since the core of society is the early adult and middle-aged patterns of mores, the use of MMPI norms based chiefly on middle-aged married persons can be justified even for young people." (pp. 24 f.) Young people have to live up to these adult mores and find release for their energies and tensions in ways acceptable to society. If they violate these middle-aged patterns of mores, these young people are regarded as delinquent. Therefore, say the editors, the application of adult norms of the MMPI to young people is proper and any adjustment of the norms to account for supposed differences between adolescents and adults is spurious. What they are saying, of course, is that if there is a difference it is one of degree rather than kind. The results of the studies appear to bear out their argument.

For the editors, the term *juvenile delinquent* refers not only to those children who have been publicly recorded as such, but also to those who, though not coming to the attention of public agencies as behavior problems, are still known to have committed acts comparable to those of the juvenile delinquents. In addition, the editors believe that delinquency is a symptom rather than a personality trait. However, certain personality types frequently develop delinquency, while other types infrequently become delinquent. These types can be differentiated, of course, by the use of objective tests. The editors also feel that to some extent personality characteristics that predispose the individual to delinquency are normal in young people. On the other hand, those children who do not become delinquent in high-risk areas of the city must have different personality characteristics from those who do succumb to delinquent pressures. Furthermore, there are supposedly those who do demonstrate personality traits likely to give rise to delinquent behavior but never become delinquent. This is because these children have never happened into a stimulus situation that would encourage their actual delinquency. Delinquency-prone personality characteristics, which would predispose them to asocial conduct, lie dormant. In all of this argument, little is said about the rôle of primary groups and institutional controls that

obviously play a highly significant part in the provocation and the prevention of delinquent behavior.

The major results from these seven studies are, for the most part, those which one would expect to find when a personality inventory is administered, for example: that girls from broken homes are more maladjusted than those from unbroken homes, that metropolitan boys are more maladjusted on the average than country boys, that the MMPI discriminated delinquents from non-delinquents in degree of personality adjustment, etc. Of greater significance is the plea by the editors for consideration of the MMPI in ascertaining potentially delinquent groups: "We believe this objective personality test approach to be, with all its limitations, much superior to the present practices in which evaluating need and effectiveness of treatment and preventive programs, if done at all, employs subjective methods that have not even been validated." (p. 140). However, the editors caution that only a responsible clinician, with careful preparation, can adequately administer the test and interpret the data. At the present time, this test may best be used to isolate groups of adolescents who are very unlikely to get into serious trouble. Again, no claim is made that this test will positively predict who will become delinquent.

ANDREW L. WADE

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HEALTH SERVICES FOR THE CHILD. By Edward R. Schlesinger, M.D., M.P.H. New York, Toronto, London: McGraw-Hill Company, 1953. 403 p.

This is a book by a physician in the public health service, addressed to the practicing pediatrician and the family doctor, on the subject of overall health services for children. It is a book of and for the present time, when practicing physicians are challenged by developments in public health—by the contributions of child psychiatry, sociology, anthropology, psychology, and social work; by movements for health in communities; and by a clientele increasingly educated and informed about the physical, emotional, and social health of children. As one of the first efforts at a comprehensive treatment of the subject, it is in many ways a good beginning and will stimulate thoughtful contributions to ways of integration in a field of concern to various professions and to many community agencies. From the author's point of orientation, such integrations are presumed to be a challenge principally to the physician in practice or in public health service. It is, indeed, a great challenge, indicated by the author's wealth of examples of emotional and social factors of child health that

must somehow be understood and related to curative and preventive health practices.

To professional workers in the field of mental hygiene, the book will be of special interest in its delineation of the scope of the problems of child health as seen by a physician in public health service with considerable experience and no small degree of sophistication in the overall health of children. Many representative and appropriate concepts of mental health are introduced and supported by references to the literature: those from the child guidance clinic field are conspicuous; those from social work are notably few. The attempt to fit social and emotional material into the form of presentation of physical material—admitting specificity, brevity, and didactic statements regarding practices to be followed—makes for obvious difficulties and inadequacies. More particularly, it makes for some misleading implications and for conveying an undynamic psychiatric orientation especially unfortunate in the designation of therapeutic interview practices. The book cannot possibly live up to Commissioner Herman E. Hilleboe's claim in his Foreword of "... a comprehensive approach to the social and emotional problems of children as well as the medical ones. ..."

The author's social and emotional health endeavor does not represent a "mental health" presentation as ordinarily understood; it does not cover mental health and fails to clarify for the reader the rôle of the medical specialty of psychiatry; it conveys only a limited idea of the potentialities of "team" relationships of the practicing physician and workers in community agencies, social and others. It is rich in illustrations and in the medical tradition of a communication from one doctor to another.

KATHARINE M. WICKMAN

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THE THIRD REVOLUTION. By Karl Stern. New York: Harcourt, Brace & Co., 1954. 306 p.

Times of war and of fear over new wars are likely to see an increased resort to religion. Of the many books illustrating such a trend today, this one by the Professor of Psychiatry at the University of Ottawa and Chief of the Psychiatry Department at the Ottawa General Hospital is important for its effort to show that psychoanalysis and religion, far from being hostile, should be allied. The third revolution, according to Auguste Comte, was to follow up the historic shift from religion to philosophy, as the major concern of the learned, by enthroning science.

In many circles, Dr. Stern contends, this exalting of science has

already occurred; and the results disquiet him. He fears that religion has already lost its hold over numbers much too large, and that the conflict between religion and science could have been avoided if, to take his own specialty as an example, the early stages of psychoanalytic knowledge had not been tainted by outmoded nineteenth-century philosophies of science—philosophies, in a word, too materialistic to be genuinely scientific. Still admiring Freud, he regrets that the master, and some disciples, too often gave the impression that psychic activity is "nothing but" other forms of mechanical behavior. He pokes deserved fun at the idea that Beethoven's *Missa Solemnis* "can be reduced to" the beating of tom-toms in the jungles, or that love is no different from sexual attraction. Reducing electricity to heat and heat to other modes of motion is legitimate in its own sphere. In this world of the psyche, however, the all-important fact is purpose or end, not origin; and awareness of this final objective calls for a different kind of thinking. Love at its highest is intent upon ends which cannot be explained as mere sublimations of sex passion. And the highest ends, to the religious, are those which call to man from the Perfect Life beyond the world of space and time.

This, to Dr. Stern, is no mere academic assertion. The very practise of psychiatry makes the thoughtful aware how necessary it is that sublimating be inspired by deep motivations: "If one really believed whole-heartedly in the primacy of blind instinctual drives and determination by the irrational, the entire idea of sublimation would make no sense. Freud has indicated time and time again that sublimation is the ideal solution of the neurotic conflict; Thomas Mann says that this alone puts him in line with the great humanists. But this means the introduction of a moral principle which is not intrinsic to the system. In psychoanalytical literature, sublimation is usually described in mechanistic terms. Since instincts, if they were freely expressed, would clash with social taboos, they are channeled into something else. Actually, nobody really believes in such a crude machinery. The very formation of the concept of sublimation implies the existence of something beyond it. Does anyone really believe that families are founded, orphans are cared for, the sick are tended to, cathedrals are erected, symphonies are composed—only because instinctual drives are blocked by society?" (p. 126)

What motive power, he asks, can compare with that exercised by religion? If religion can fill men with the strength to love even their worst enemies, to practise the most rigid austerities, to endure tortures, to brave such perils as countless noble missionaries have indeed faced, it still can do something for neurotics and psychotics so sadly in need of a motive power that will impel them to make over their lives.

In his autobiography, *Pillar of Fire* (Same publishers, 1951), the author says:

> "Christianity teaches us that the climax of human perfection is to love infinitely, to be able to be hated infinitely. This degree of human maturity has been reached perhaps only once in history, in the person of Jesus Christ. Psychoanalysis teaches us that *Amor* can be transformed into *Caritas*. So does Christianity. Later generations will see that in the rediscovery of the crude archaic traces of 'love' in Man's physical nature, there occurs a decisive turning-away from that Manichaeism of which Western Man has been so dangerously ill. Moreover, psychoanalysis with its detailed care for the history of each individual and its emphasis on psychic injuries, reaffirms, more than any other discipline in psychiatry or psychology, the dignity of the human person. This is, in the end, one of the reasons why psychoanalysis has been rejected by Communists and Nazis alike. Freud's atheistic philosophy is a tragic historical accident, but it is an accident. His philosophical statements are amateurish and contradictory, and they can easily be separated from his psychology without doing harm to the latter." (p. 279)

A convert from Judaism to Catholicism, after he had fled from Germany to England and then to Quebec, Dr. Stern, master of an English which many a native might envy, rises to a fervid eloquence whenever a champion of science calls religion nothing but an obsessive-compulsive neurosis. He grants that there are stages where this characterization fits. But to apply such debunking to religion at the higher levels, he says, is as scientific as to insist that the face of Michaelangelo's David is nothing more than the face of David the foetus "with bulb-like eye lids, a gaping slit for a mouth, and the arches of gills underneath." Such reduction of the higher to the lower has made the tragic history of our day possible: "There is a direct line leading from Darwin to Hitler" (p. 129). An authority on gall wasps, Kinsey does not thereby qualify as a guide to the sex morals of human beings. Instead, therefore, of the primacy of the biological, Dr. Stern wants the primacy of the theological. One must go beyond the order of Nature to find the design for the life of man. Nothing can so give proper direction and inspiration for sublimation as Christian (*i.e.*, Catholic) personalism. Not in machines, not in beasts, not in man on his animal side can the Holy Ghost ever dwell.

With this plea to deepen and enrich psychoanalysis by invoking the Christian moral conscience, nobody can quarrel—when the religion is already a genuine thing in the life of the person seeking mental health. But Dr. Stern is surely psychologist enough to know that people differ in their central motivations. He can scarcely deny that many an excellent psychiatrist, unable to accept Judaism or any kind of Christianity, can be a person of high integrity and fine scruple, as genuinely concerned to help his patients into healing as a doctor to whom love is unthinkable without God either as Father or as Son.

Nor can he want a Catholic physician first to make sure that a non-Catholic patient is converted. Some religious persons are indeed imperialists, not at all satisfied with the co-existence of other religions, or irreligions, but zealous for the dominance of their own (to them) perfect set of dogmas. The true physician, it would seem, is the one who tries to enlist the motivations which appeal most, not to himself, but to the patient.

Of such impulsions, experience abundantly shows, there are many kinds. The self-giving on the part of the religious can be seen in human love inside and outside the family. It is shown in ardent patriotism. Thorstein Veblen was so impressed by the way so many people feel a workman-like sense of a job that just has to be done if only to keep their own self-respect, that he wrote a book entitled "The Instinct of Workmanship." If persons so moved can be guilty of follies or worse, may not the same fact be observed in the conduct of the religious?

The problem raised by Dr. Stern is not quite so new. See, for example, Erich Fromm's *Psychoanalysis and Religion* (reviewed in MENTAL HYGIENE, Vol. 35, pp. 302–04, April, 1954). Unlike Fromm, Stern is convinced that the third revolution will bring about, to quote his autobiography, "a scientific social apparatus in which the triad of Faith, Hope and Charity will be entirely replaced by a triad of Research, Insurance and Management" (*Pillar of Fire*, p. 260). A statement like this is hardly scientific. It is a guess; fallible and inspired by a common human prejudice. Must the three instruments employed by science necessarily lack the other three essentials? Is a physician sure to be utterly cold-hearted when he keeps cool in his search for the best way to treat a sufferer? And it is easy just now to forget what errors and even crimes can be committed in the name of the religious triad too.

Some scientists are equally unfair in minimizing the values to be found in religion. It does seem, therefore, that we are more likely to move ahead in the main business of living if we conscientiously study those values and apply them instead of wasting good human energies in squabbling over which claimant is their only legitimate heir and custodian.

HENRY NEUMANN

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How To BE A WOMAN. By Lawrence K. and Mary Frank. New York: The Bobbs-Merrill Co., Inc., 1954. 141 p.

In the introduction, the authors state their thesis concerning the problems of women; that the various changes in family life, and the change in the stereotyped male and female rôles brings confusion and

conflict. The book, they say, is offered as assistance in the struggle. The book takes the view that human living is a series of turning points or transitions, and that each offers an opportunity to change, to build anew, to benefit by experience, to learn from experience mistakes and to be better able to meet tomorrow. These turning points form the chapters of the book: "Girlhood," "The Young Woman," "The Busy Years, 20–40," "The Growing Child," "The Middle Years, 40–55," "The Later Years, 55–on."

The ability to formulate simply and clearly the concepts of emotional development and emotional adjustment in the various periods of life of a woman is truly an art. The authors have done this in a most agreeable manner. The task they set for themselves was herculean and yet they have, in a short number of pages, included the significant concepts, given understanding and insight to enable the reader also to use them. The language is clear, the style warm, sympathetic, and friendly. One gets a feeling that the authors are truly interested in their readers, and humble in their contribution.

The book demonstrates the efficacy of the team work of the husband and wife. There is the realization and appreciation of the difficulties of the woman in the aspirations of fulfilling her rôle as a woman.

It would be difficult to select any particular statement made by the authors which is vital in understanding human behavior, for the book is replete with them. So many of them will be completely new to the young and the older women who read them—and very much at variance with what they had experienced from their own parents. But the statements are made with such simplicity, clarity and reasonableness that they will undoubtedly be convincing.

The significant anatomical and physiological developments in the various periods of a woman's life are also discussed.

The authors have woven the concepts into very practical information. Yet there is no attempt to be authoritarian or moral in discussing what they think is a more desirable form of behavior. Generalities are expressed with a recognition of the uniqueness of each woman they are addressing: "You should decide," or, "You should know," and, "The surest guide is your own feelings and goals." In discussing behavior involving a male partner, they discuss it in a framework of the woman's needs, awareness of the partner's needs, and awareness of the setting—society. Reading this small comprehensive volume gives an excellent background and will stimulate interest in further reading in the specific period the reader is in.

The significance of the contribution the authors make is well stated by them: "Far more important than anything that is said in it will be your response to it, the personal feelings and actions it may inspire." These feelings—your belief in yourself as a woman, the degree of your confidence and courage in facing the promises and

hazards of life—are crucial to the world today. For what you decide to do with your life, and whether you, and all women, can find happiness, pride, and fulfillment in being feminine, will have vast influence on the future of humanity."

LENA LEVINE

*New York City*

HELPING YOUR CHILD'S EMOTIONAL GROWTH: A PICTORIAL GUIDE FOR PARENTS. By Anna W. M. Wolf and Suzanne Szasz. New York: Doubleday and Company, 1954. p. 305.

Anna W. M. Wolf presents an extremely readable, down-to-earth, and constructive discourse on child development, highlighted with incidents from real situations in which parents have utilized opportunities for growth experience. Suzanne Szasz enhances the volume with her living photographs of children and family scenes which illustrate the author's material, and, frequently, appear in sequence to tell their own story.

It would be difficult for the reviewer to express preference for any one section of the book. However, the opening section on "Don't Expect to Be Perfect," "Bedtime Problems," and "The Child Who Is Shy" can be considered vignettes in their own right. In concluding her discussion on shyness, the author says: "If you find there's just one other child with whom yours likes to play, encourage the friendship. Don't belittle it or try to force your child prematurely into being a good mixer."

*Helping Your Child's Emotional Growth* embodies a happy compound of sound mental-health principles, a humanistic approach, and a variety of examples, all of which are pertinent to everyday living. The "Photographer's Note" explains the conditions under which the photographs were taken. A bibliography of other books for parents contains excellent suggestions for reading materials on "The Early Years," "Family Life," and special subjects. Finally, a well-done index makes for facile referral to the subjects covered in the content. Although directed to parents, this volume would be helpful to caseworkers and group workers, to pediatric nurses, and to staffs of children's facilities, including day nurseries and nursery schools.

MARYAN H. BRUGGER

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PSYCHIATRY FOR THE FAMILY PHYSICIAN. By C. Knight Aldrich, M.D. New York: McGraw-Hill Book Company, Inc., 1955. 276 p.

As its title reads, this is an important book, especially valuable at the present stage of the development of medical education. It is of particular interest as growing out of the University of Minnesota Department of Psychiatry, where Professor Donald W. Hastings has

been giving for years now careful consideration to the application of psychological medicine in general practice.

*Psychiatry for the Family Physician,* over and above its specific helpfulness as a worthy experimental test, respects the family physician's *necessity* to practice psychological medicine. It is applicable both in undergraduate and post-graduate medical training. Helpful efforts in this direction are warmly welcomed by today's medical educator who is concerning himself with "continuity of medical care," "psychiatric training of the general practitioner," "pediatric psychiatry," "home medical care," "health education," and "family medical counselling and training opportunities for the undergraduate medical student."

Dr. Aldrich has planned the major part of his book as a "step-by-step outline of emotional growth and development." The various developmental problems frequently coming to the family physician's attention are reported and discussed, and methods are offered which the physician can "integrate into his approach of a diagnosis and treatment of any patient." To a gratifying degree, the concept of the patient's rôle in his own treatment is observed, and allusions to prescriptions of violent force are correspondingly brief. The book has a useful bibliography and index.

Dr. Aldrich calls attention to compelling health interests such as "school living," "religious education," "retirement," "alcoholism," "divorce," "rooming in," the "psychologist," "obseity," "menopause," "mourning," and "individuality."

One finishes reading this text with a lively appreciation that Dr. Aldrich is aware of the need for continuing opportunities for (1) the family physician to avail himself of all helpful findings occurring in psychological medicine, and (2) the psychiatrist to inform himself of all of the useful viewpoints occurring in family practice.

May there be later editions of this book, and may every physician excite his consciousness with the need for his comprehensive study and practice of himself in medicine.

JOHN M. DORSEY

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PYGMIES AND DREAM GIANTS. By Kilton Stewart. New York: W. W. Norton & Co.

Kilton Stewart's dramatic experiences among the "primitive" people of the Philippines is a revelation of one man's ingenuity and imaginative power as he enters into the initimate life of those people who for most of the world are only dim figures in a primeval forest. Dr. Stewart introduces us to the universal in all mankind through his personal experience and through the materials drawn from his

search for laws of psychotherapy that are applicable to the simple as well as to the sophisticate.

Particularly interesting are his descriptions of hypnosis and the trance-state, and the way in which the shamans, working rythmically in a group, build, through the images in the patient's dreams, new creative products in the form of music, posture, and words. The psychic release in those areas of personality which once expressed themselves in conflict could thereafter be expressed in music, poetry, or dance. This understanding leads to a new appreciation of the significance of the folk tale, ceremonies that accompany many phases of primitive life, and the central place of rhythms and dance forms.

New meaning was given to the pattern of life of the primitive, as Dr. Stewart described the dream origins of many of their concepts and ideas, and one saw these as blocking social change—and thus social progress, or as contributing to the social life of the individual or the group.

The fact that the intense personal involvement of the writer seems to take precedence over the Scientist's more detached perspective gives the reader a continuing impression of fantasy even in those moments when one wishes most to find in the story a new contribution to the field of Social-psychology which the book undoubtedly is for, as the dedication implies ". . . all men—are pygmies, except as their stature is increased from day to day by the dream giants."

DOREEN B. GAMBOA

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AFTER THE DOCTOR LEAVES. By Marguerite Clark. New York: Crown Publishers, 1954. 310 p.

Mrs. Clark, the medical editor of *Newsweek*, has written an excellent compendium on the present status of medical science, admirably interpreted for the educated reader. One is impressed by the author's personal investigations in medical centers and her extensive research in medical literature. The book, a good guide to long, healthy living, deserves a very wide circulation. It is a far sounder book than several recent ones that oversimplify medical problems and promise techniques for living happily every day in the year.

The book is divided into a dozen chapters, all but one of which deal with diseases of the bodily systems. The pros and cons of controversial problems in heart and circulatory diseases, cancer, rheumatism, ulcers and other disorders are objectively presented. In these discussions the concept of the whole man is usually kept in view, and the psychiatric aspects of organic disease are well represented. The emphasis upon chronic diseases and the way in which the patient may learn to live with his handicap are well explained; they offer a good example of psychotherapy through education.

The excellent, long discussion of mental and emotional problems covers the field adequately in most respects, tracing the appropriate types of treatment now available to patients with various mental disorders. The final chapter, "When You Grow Old," reviews fully the medical and social problems that face the fast increasing number of persons who live to be old—with a thoughtful interpretation of what is "old." The factual, realistic discussion contains much practical information and also explains the rôle of psychiatry in aiding people to better adjustment in their later years.

A few limitations, to be expected in a popular book of this scope, may be pointed out. The advice given to cancer patients does not mention the prevalence of cancer phobias and the often serious results of the phobia; for example, suicide in patients who fear the presence of cancer or whose disease could probably be controlled for a number of years. Likewise, the chapter on allergies omits the neurotic allergies seen frequently in medical practice. Except for migraine, headaches are considered wholly as symptoms of disorders of the nervous system, and the commonest form of headaches, that due to neurosis, is barely noted. Cerebral palsy receives a small fraction of the space given to poliomyelitis, a far less prevalent disease, nor is there any mention of cerebral anoxia as a cause of cerebral palsy and what can be done to reduce the incidence of brain damage during labor.

In her excellent discussion of mental and emotional illnesses, the author notes that the mental hospital "should be as easy to enter as the general hospital," but she ignores the value of early diagnosis and treatment of mental disorder in the psychiatric unit of a general hospital. The rapidly expanding trend toward general hospital psychiatry allows the mental patient to find treatment on the same level as do surgical or other medical patients, and thus really lifts the bar of discrimination and prejudice against mental disorders.

I do not quite agree with the statement in the foreword that very complex scientific findings are here presented in simple, understandable terms. The book is very well written, but many lay persons would require a medical dictionary to understand some of the terminology, much of which is highly technical.

Although the title, *After the Doctor Leaves,* is intriguing, it limits unduly both the content and usefulness, since the book emphasizes throughout the need for information at all stages of illness and for continuing medical care.

The book's wide range of medical information and its easy style makes it of great value. It should interest all lay readers who wish to keep abreast of the scientific advances in medicine.

A. E. Bennett

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# NOTES AND COMMENTS

## Efforts of New York Group Aids Aliens in Mental Hospitals

The New York Association for the Improvement of Mental Hospitals recently initiated efforts which resulted in relieving families of aliens in state mental hospitals of what had been a grave burden—financial and emotional. The problem concerned those alien patients confined in state mental hospitals within five years after entry into the U. S. and possibly liable for deportation as public charges.

The New York group was apprised that families of such alien patients in N. Y. State hospitals were paying more for the care of their relatives than families of non-alien patients of similar financial status, in the hope of averting deportation proceedings. The Association undertook to ascertain whether this was legally necessary—whether the State Mental Hygiene Dept. was obliged to report as a public charge an alien patient who was paying less than the full reimbursement rate, even though the amount which was being paid was all the patient or his relatives could afford. For many families of alien patients this problem was a tremendous one and many suffered serious financial hardships because they were paying full hospital fees, when they were in no position to do so.

After communicating with the N. Y. State Dept. of Mental Hygiene regarding the status of such alien patients, the Association obtained an opinion from the U. S. Immigration and Naturalization Service. This opinion indicated that there is no Federal rule or regulation which requires a department of mental hygiene to demand that an alien pay the full reimbursement rate, and that a department is not required to demand that an alien pay more than the non-alien of similar financial status. Since the reimbursement rates are set by the local government or institution purely as a matter of their own convenience, they have no bearing on deportability. As long as the family or alien is paying all it can financially afford, and the state authorities do not demand a greater amount, an alien patient in a mental hospital cannot be found deportable as a public charge on this basis.

When the N. Y. Dept. of Mental Hygiene was informed of this opinion, they found they could handle the problem by merely revising their own practices, without any statutory changes. With the clarification obtained, the whole picture has been changed in New York State . . . to the great benefit of many such alien patients and their families.

The work of the New York Association for the Improvement of Mental Hospitals in this matter deserves commendation. It is a problem which might well be a subject of inquiry in other states by other groups.

### Dates for 1956 Mental Health Week Announced

The 8th annual observance of Mental Health Week will take place April 29 through May 5, it is announced by the National Association for Mental Health, which will again direct and coördinate the nation-wide event with the co-sponsorship of the National Institute of Mental Health.

Mental Health Week has become the traditional high-point in the year-round efforts to focus attention on mental health and the problems of mental illness and to mobilize the efforts of people in all parts of the country.

Invited to participate in the observance of Mental Health Week are government agencies, voluntary and professional organizations, hospitals, clinics, schools, unions, business firms, religious associations and churches, civic, service, and other clubs, and other national and community groups interested in the mental health field.

### A Different Kind of Hospital Volunteer Program

The Maryland Association for Mental Health has initiated a new program in coöperation with a mental hospital, which its Executive Director, Mrs. Gerturde Nilsson, thinks might be called "volunteer service in reverse."

Working with the Rehabilitation Dept. of Spring Grove State Hospital, the Mental Health Association is using as volunteers in its office patients from the hospital who need a trial experience at work in order to help prepare them for leaving the hospital and readjusting to jobs in the community.

The Association and the hospital staff are equally enthusiastic about the results of the new project. The first patients to work as volunteers at the Association office were all experienced office workers. They were efficient, responsible, and pleased to be able to be of service to the mental health movement at the same time they made progress towards their own recovery.

The merits of this new program are many—and mutually beneficial. Working in the Mental Health Association office has been of great help to the patients; the Association is able to provide references of recent date for the ex-volunteers who leave the hospital and apply for jobs in their community; the staff and other volunteers who work at the Association office become much better informed about those

who have been mentally ill. Their feeling has grown much more positive and knowledgeable as only first-hand contact can really achieve. In addition, the Association has been able to step-up the volume of work turned out, with the assistance of the hospital volunteers.

Mrs. Nilsson anticipates that this fall the project will provide the impetus for the organization of an ex-patients' club, under the auspices of the Maryland Association, to offer ex-patients an opportunity to discuss their hospital experience, consider the problems of community adjustment and the unmet needs of their group, and to work within the framework of the comprehensive volunteer mental health movement for the benefit of those patients still in the hospital.

### Stipends for Psychiatric Nursing Study Awarded

Award of seven stipends to graduate nurses for one year of advanced study in psychiatric nursing during 1955–1956 has been announced by the Minn. Dept. of Welfare. Five of the recipients will study at the Univ. of Minnesota and two at Teachers College, Columbia Univ. Professional nurses who accept these stipends agree to return to Minn. state hospitals for at least one year following the year of study. The seven awards for 1955–56 makes a total of 23 awarded since the program was started in 1952.

### Seven Professional Groups Merge to Form New National Social Workers Association

This month the National Association for Social Workers will come into being, with a membership of over 20,000 professional social workers from seven national organizations. The merger took place following a mail referendum to members. The seven groups are: American Association of Group Workers, American Association of Medical Social Workers, American Association of Psychiatric Social Workers, American Association of Social Workers, Association for the Study of Community Organization, National Association of School Social Workers and the Social Work Research Group.

The new national group will be organized across the United States, with 150 chapters. Five initial sections are being set up—group work, medical social work, psychiatric social work, school social work, and social work research.

It is felt by its organizers that the new association will be able to utilize more effectively the resources of the social work profession and to eliminate duplication of organizational efforts. The association will be operated by six committees, the coördination of which, it is said, will provide one program much broader in intent and scope than the programs of the seven separate associations.

### Report on "Retirement Forum" of Philadelphia Firm

Since the John B. Stetson Co., Philadelphia, inaugurated its "retirement forum" for employees facing retirement age (See "Notes and Comments," Mental Hygiene, October, 1954, p. 695) three important lessons have been learned, according to Horton Delaney, organizer of the project, whose report is summarized in the bulletin *Aging* published by the U. S. Dept. of Health, Welfare, and Education:

> "(1) The more spadework, the better! Time must also be spent contemplating the best way of putting across the material. Not only will there be vocabulary and language difficulties, but also mental barriers such as anti-company attitudes or the 'all-we-need-is-the-money attitude'.
>
> "(2) It is necessary to attempt to determine the particular decrement or loss in life each employee will suffer when he retires. Some will have financial problems; others, social problems; some will develop health problems. Rather than making package recommendations for the entire group, discussion leaders must get each individual thinking about how to compensate for his particular decrement, how to solve his own problems.
>
> "(3) Finally, employees benefit in direct proportion to the active role they are made to plan in the program. The more they participate and become involved by talking, demonstrating, acting as a discussion leader —the more the 'Retirement Forum' will become a part of them."

The Stetson plan was awarded the 1953 Award of Merit of the Research Institute of America, and has since its inception been most successful. Additional information about the retirement forum may be obtained by writing to Albert M. Kreger, Manager, Employee Development, at the John B. Stetson Co., Philadelphia.

### NAMH Fifth Annual Meeting

The Fifth Annual Meeting of the National Association for Mental Health will be held November 3 through November 6 in Indianapolis, Ind., with headquarters at the Sheraton-Lincoln Hotel. (The meeting has been shortened from the previously announced schedule, but there has been no change in the dates of the program sessions, which will begin on Friday, November 4.)

At the opening luncheon on Friday, the keynote address, "Mental Illness—A Challenge to the Nation," will be presented by Sidney Spector, Director, Interstate Clearing House on Mental Health, the Council of State Governments. Subsequent sessions of the conference will focus generally on "meeting the challenge." Panel discussions, small-group discussion periods, as well as addresses by authorities in the mental health and allied fields, have been scheduled to take up topics such as: "Programming in Mental Health," "What Does the Public Know about Mental Illness?", "Does the Public Care About Mental Illness?", "Informing and Convincing the Public," "Edu-

cational Activities for Mental Health Associations," "Research." Film previews will be held and special exhibits will be on display.

The Hon. Luther Youngdahl, U. S. District Judge and former Governor of Minnesota, will present the major address at the Annual Banquet, on Saturday night.

Copies of the Preliminary Program and advance registration forms are available from the National Association for Mental Health, 1790 Broadway, New York 19, N. Y.

### Other Meetings and Conferences

The American Occupational Therapy Association will conduct its 38th Annual Conference and Institute at the Sheraton-Palace Hotel, San Francisco, October 25 through 28. The general theme will be "Bridges to the Future." A pre-conference institute, "The Patients Point of View" will be held October 24th and 25th. Meetings of the institute are not open to the general public except by special arrangement. The Conference itself will begin on the evening of October 25. Copies of the Preliminary Program and further information are available from the Association, 33 West 42nd St., New York 36.

The Third Interamerican Congress of Psychology sponsored by the Inter-American Society for Psychology for its members and selected delegates from the U.S.A., Canada, and various Latin American countries, will be held December 16–21 at the University of Texas, Austin. The University and the Hogg Foundation for Mental Hygiene will serve as hosts. Central theme of the Congress will be "Psychology of Social Tensions." There will be four major symposia, plus conferences, film showings and discussions, and guided tours. Congress information or information on membership may be obtained from Wayne Holtzman, Chairman of the Committee on Arrangements, University of Texas, Austin.

Reports on a variety of mental health developments related to public health will be presented before the 83rd Annual Meeting of the American Public Health Association and meetings of 40 related organizations in Kansas City, Missouri, November 14–18. Overall theme of the meetings is "Where Are We Going in Public Health." More than 400 scientific papers will be presented during the conference sessions. The tentative program announced by Dr. Reginald M. Atwater, Exec. Secy. of the Association, includes the following papers of special interest to the mental health field: "The Mental Health Problem in Older People"; "Mental Health—The New Frontier"; "The Drift Hypothesis and Socio-Economic Differential in Schizophrenia"; "Maternal and Fetal Factors in the Occurrence and Degree of Mental Deficiency"; "The Mentally Retarded Chil-

dren in a Metropolitan County"; "Mental Health of Older People in a Metropolitan County," and "Neuropsychiatric Sequalae of Prematurity."

The 13th Annual Conference of the American Group Psychotherapy Association will be held January 13 and 14 at the Henry Hudson Hotel in New York City. Six all-day workshops have been planned for the first day, with topics to include: The Dynamics of Group Psychotherapy; The Rôle of the Therapist; Resistance in Group Psychotherapy; Parallel Individual and Group Psychotherapy; Counter-indications for Group Psychotherapy, and Research. Special registration will be required for these workshops. For the morning of Saturday, January 14, six round-tables have been arranged. The subjects of these are: Differential Levels of Group Treatment of Parents of Children; Special Problems in Group Therapy; Total Group Treatment in Mental Hospitals; Group Psychotherapy with Children; Group Psychotherapy with Ambulatory Schizophrenic and Borderline Cases. Three scientific sessions will also be held and films dealing with group psychotherapy will be shown. For further information inquire of the Association at 228 East 19th Street, New York 3.

The 1956 National Health Forum, held each year under the sponsorship of the National Health Council, will be presented this year in New York City on March 21 and 22. Dr. Theodore G. Klumpp, president of Winthrop-Stearns, Inc., and a vice president of the Council, will be chairman of the 1956 Forum. The Planning Committee for the 1956 Forum has recommended that the spring conference concern itself with chronic illness—to identify specific activities underway to improve the care of the long-term patient, and to point up community responsibility for concerted action on chronic illness.

The 33rd Annual Meeting of the American Orthopsychiatric Association has been scheduled for March 15–17, in New York City. Further information may be obtained from the Association at 1790 Broadway, New York.

The American Psychosomatic Society will hold its 13th Annual Meeting at the Sheraton-Plaza Hotel in Boston on Saturday and Sunday March 24 and 25, 1956. The Program Committee has requested titles and abstracts of papers for consideration for the program by December 1, 1955. The time allotted for the presentation of each paper will be 20 minutes. Abstracts should be submitted in sextuplicate for the Committee's consideration to Stanley Cobb, M.D., Chairman, Program Committee, 551 Madison Avenue, New York 22.

The Second International Congress for Psychiatry will be held in Zurich, Sept. 1 through 7, 1957. Subject of the Congress will be

"The Present Status of Our Knowledge About the Group of Schizophrenias." Four major meetings are planned for discussion of the subject, while another major session will be organized for the discussion of practical questions about therapy. The final program will be released at a later date.

The Seventh Mental Hospital Institute to be presented by the American Psychiatric Association Mental Hospital Service was held October 3–6 in Washington, D. C. Theme of the Institute was "Patient Participation in Treatment." A report of highlights of this conference will be carried in a subsequent issue of MENTAL HYGIENE.

The Astor Home, Rhinebeck, N. Y., a residential center for research and treatment for emotionally disturbed children has announced its First Annual Conference on Child Treatment, to be held October 10. Dr. Joseph J. Reidy, Medical Director, said that participants would include Drs. Frank J. O'Brien, Leo H. Bartemeier, Harvey J. Tompkins, Ralph D. Rabinovitch, and Earl Loomis, Jr.

## PUBLICATIONS OF INTEREST

*Hospitals*, journal of the American Hospital Association, features in its August issue, part I, a series of articles on "The Greatest Single Health Problem—Mental Illness," plus a guest editorial by Francis J. Braceland, M.D., Dir. of the Institute of Living, Hartford, who writes on the need for reintegration of psychiatry into general hospitals. Articles include: "The Administrator's Rôle in Developing a Psychiatric Unit in a General Hospital," by Lee G. Sewall, M.D., manager of the V. A. hospital at Downey, Ill.; "The Anniversary of a Belief" the story of St. Elizabeths Hospital in Washington, D. C., written by Winfred Overholser, M.D., the hospital's superintendent; "Understanding Opens Doors," a discussion of the opportunities for hospital auxiliary service in fields of mental health, by Mrs. Albert C. Rood, member of the Committee on Hospital Auxiliaries of the Am. Hospital Assoc.; "The Emotional Aspects of Physical Illness," a report on a series of seminars conducted in the Manhattan, Kansas, area with the coöperation of the Riley County Mental Health Association, aimed at acquainting hospital personnel with this important problem, written by Weir Richard Kirk, Administrator of the Riley County Hospital, and Roman J. Verhaalen, Ph.D., associate professor of adult education, Kansas State College; and "'Wing R' Insures Integrated Care," by Carl Mosher, Asst. Administrator of Strong Memorial Hospital, Rochester, N. Y., which gives a detailed account of how the hospitals psychiatric unit is integrated with other hospital units, avoiding costly duplicate services and facilities.

*Signs of the Health Times,* a condensed report of the public-interest portion of the program of the March 1955 National Health Forum on "Forecasting America's Health" is now available from the National Health Council. The 64-page booklet includes well-prepared summaries of the major sessions of the Health Forum. Available at $1 per copy from the National Health Council, 1790 Broadway, New York 19. Reduced prices are offered for quantities.

*The International Journal of Social Psychiatry,* a quarterly journal published in London, made its debut this summer. Edited by Joshua Bierer, Md., D. Econ. and Soc. Sc., and Thomas A. C. Rennie, M.D., the pocket-size journal includes articles from well-known authorities of many nations, brief reports on general developments in the field, and book reviews. Subscription in the United States and Canada is $5 per year, and should be sent to The Editor, The International Journal of Social Psychiatry, 9 Fellows Road, London N.W. 3, Great Britain. Single copies are $1.50 each.

Recently published by the National Institute of Mental Health is a *Listing of Outpatient Psychiatric Clinics,* which includes information received through June 30, 1954. The book is intended to serve as an interim reference on existing mental health clinics, and will be succeeded by a new *Directory of Outpatient Psychiatric Clinics* currently being prepared as a joint publication of the National Association for Mental Health and NIMH. Copies of the present *Listing* (Public Health Service Publication No. 428) may be obtained from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., at 35 cents per copy. A discount of 25 per cent will be allowed on all orders for 100 or more copies to be mailed to one address.

*Reaching Adolescents Through a Court Clinic,* recently published by the New York City Youth Board, deals with a pilot project concerned chiefly with the problem—can a psychiatric clinic for adolescents function successfully in a court setting and how it can do so. The 62-page booklet describes the intake process and the various ways in which clinic services may be used, and explains the rôle of the therapist and the division of responsibility between members of the clinic staff. Case studies taken from clinic records add to the picture of the operation of the psychiatric unit in the court framework. The monograph concludes with an analysis of the clinic caseload and treatment costs, and the relationships between the court, the clinic, and the community. The major finding reported in the pamphlet is that resistant adolescents *can* be brought into treatment, despite the fact that they do not come on their own initiative and are often suspicious and fearful of the therapist. The pamphlet is available from the

New York City Youth Board, 500 Park Avenue, New York 22, at a price of 50¢ per copy.

Proceedings of the Sixth Mental Hospital Institute, held under the sponsorship of the Mental Hospital Service of the American Psychiatric Association, in Minneapolis, last October, have been published in a paper-bound, 134-page book edited by Harvey J. Tompkins, M.D., Chairman of the Institute Program Committee. Contents include the text of "Trends in Mental Hospital Administration" by Arthur P. Noyes, M.D., 1954–54 APA President; "Critique of Somatic Therapies," an academic lecture by Lauren H. Smith, M.D. Review of all discussion sessions held at the Institute are given in succinct form. Copies of the *Proceedings* may be ordered from the APA Mental Hospital Service, 1785 Massachusetts Ave., N.W., Washington 6, D. C. Price is $2 per copy.

Two popular-appeal pamphlets, latest in the child training series of the Mental Health Div. of the Dept. of National Health and Welfare, Ottawa, Canada, have recently been released. Entitled "Sleeping Habits" and "Jealousy," the illustrated folders offer easy-to-understand information to parents, teachers, and others concerned with young children.

Publication of a new quarterly concerned with sociometry, group psychotherapy, and psychodrama, has been announced by the Beacon House publishing firm. Titled *International*, it will be published in five languages—English, French, German, Spanish, and Italian. The editorial staff of international authorities will be headed by J. L. Moreno. The publication is scheduled to commence March, 1956. Annual subscription is $4. Inquires should be sent to Beacon House, P.O. Box 311, Beacon, N. Y.

Problems of college students and ways in which college faculty and administration can aid the personality development of students are well-discussed in the recent publication *Considerations of Personality Development in College Students*, prepared by the Committee on the College Student, Group for the Advancement of Psychiatry. Written primarily for educators, the report should prove of interest also to others concerned with fostering good mental health through promoting the understanding and efforts of those who are the "key people" in every individual's life. The five main sections of the report are concerned with personality development in the college students, the rôles of the college administration and the faculty in aiding this development, the relationship of the college with the student's family, and how the services of the psychiatrist can be utilized in the college. Somewhat longer than most GAP reports (this one runs over nine

pages, plus a comprehensive list of suggested reading), *Considerations on Personality Development in College Students* is 50¢ per copy, available from The Group for the Advancement of Psychiatry, 3617 W. Sixth Ave., Topeka, Kansas.

*Psychiatry and Marital Problems: Mental Health Implications*, an article which originally appeared in Eugenics Quarterly, June, 1955, has been issued in reprint form by the American Eugenics Society. Written by Emily Hartshorne Mudd, Assistant Professor of Family Study in Psychiatry, School of Medicine, and Director of the Marriage Council of Philadelphia, Univ. of Pennsylvania, the paper is devoted to a discussion of marriage counseling—a definition, history, and evaluation—and how adequate marraige counseling facilities can offer a service "auxiliary to that of psychiatry toward the mental health of the community." Copies of the reprint are available from the American Eugenics Society, Inc., 230 Park Ave., New York 17, N. Y. The price is 25¢.

The American Hospital Association has expanded its publication of statistics to include the annual hospital census and hospital registration which were formerly undertaken by the American Medical Association. The AHA's *Administrators' Guide*, published in August, incorporates the type of statistics, tables, and information formerly carried in the *Census of Hospitals* of the AMA. All of this is published in addition to the information which the annual *Guide* regularly contained in the past. It is a valuable volume of reference.

In the July, 1955, issue of the *American Journal of Psychiatry*, published by the APA, there is presented nine tables which give a great many up-to-date facts and figures of interest to all in the mental health field. Grouped under the overall title "The Current Picture of Mental Health and Psychiatry in the U. S.," the tables represent work by Daniel Blain, Kenneth Appel, Albert E. Scheflen, and Robert L. Robinson, who compiled them for presentation at the 110th Annual Meeting of the APA. Included are statistics on movement of mental hospital population, the extent of social illness, the cost of mental illness, comparative expenditures for research, the need for personal in mental hospitals, the "treadmill of expenditures" for custodial care, and a comparison of national consumer expenditures and mental health research expenditures.

### Notes for After Fifty

The National Association for Mental Health announces publication of *Notes for After Fifty,* an original series of six illustrated messages for distribution to men and women 50–60 years of age.

The aim of the *Notes* is to encourage people to examine honestly some of the problems they are quite certain to face as they grow older, while there is still adequate time to plan and prepare for them. The *Notes* are designed to be mailed separately, a week or two apart, so that the individual has a chance to reflect on the contents of one before he moves on to the next topic. NAMH suggests that the series be followed with an opportunity for individual or group counseling.

Contents of the series include: attitudes and facts about aging, improving and keeping one's health, living within an older body, taking advantage of modern devices and services, continued growth through new skills and interests, self-understanding in money matters, living arrangements, and relationships with family, friends, and community.

Written in popular style by Edith M. Stern, author of *Mental Illness—A Guide for the Family* and other books and magazine articles, *Notes for After Fifty* incorporates the suggestions of leading authorities in the fields of aging, mental health and human relations, assuring soundness of psychiatric, medical, and social content. The series was conceived by Edward Linzer, Director of Education and Program Services of NAMH, who also served as editorial consultant.

The series is appropriate for mailing by private-practice professionals to patients and clients, as well as by employers, unions, and community groups in contact with the older worker. There is space at the conclusion of each *Note* for the imprint of the donor.

*Notes for After Fifty* can be obtained through the National Association for Mental Health, 1790 Broadway, New York 19, and its affiliated state and local mental health associations. Sample sets (six *Notes*) are $1 prepaid; in quantities of 100 sets are 35¢ each. Quantity rates for 1,000 or more sets will be supplied on request.